

IRON

Ques- Discuss the importance of Iron in our body.

Ans-Iron is an essential element for the formation of haemoglobin of red cells of blood and plays an important role in the transport of oxygen. Tissues also require iron for various oxidation-reduction reactions. Most of the iron in the body is reutilized and some of the body iron is also stored in liver and spleen. The amount of iron to be absorbed from the daily diet is quite small. It is in the neighbourhood of 1-3mg dependent upon the sex and the physiological status. Since there is limited capacity to absorb dietary iron, diet should contain 10-25 fold iron required daily.

Ques-What is Nutritional Anaemia?

Ans-Anaemia is the decreased ability of the red blood cells to provide adequate oxygen to body tissues.

Ques- What are the causes (nutritional) of anaemia?

Ans- Nutritional Anaemia develops slowly after the normal stores of iron have been depleted in the body and in the bone marrow. Women, in general, have smaller stores of iron than men and have increased loss through menstruation, placing them at higher risk for nutritional anaemia.

- It may be due to a decreased number of red blood cells,
- a decreased amount of substance in red blood cells, which transports oxygen (hemoglobin),
- Or a decreased volume of red blood cells.
- The causes of iron deficiency are:
- too little iron in the diet,
- poor absorption of iron by the body,
- and loss of blood (including from heavy menstrual bleeding).

Ques- Give the types of anaemia?

Ans-TYPES OF ANAEMIA

- anaemia of B12 deficiency
- anaemia of chronic disease
- anaemia of folate deficiency
- drug-induced immune hemolytic anaemia
- hemolytic anaemia
- hemolytic anaemia due to g6pd deficiency
- idiopathic aplastic anaemia
- idiopathic autoimmune hemolytic anaemia
- immune hemolytic anaemia
- iron deficiency anaemia
- pernicious anaemia

- secondary aplastic anaemia
- sickle cell anaemia

Ques-Who are at a higher risk of developing iron deficiency anaemia?

Ans- High-risk groups include: women of child-bearing age who have blood loss through menstruation; pregnant or lactating women who have an increased requirement for iron; infants, children, and adolescents in rapid growth phases; and people with a poor dietary intake of iron through a diet of little or no meat or eggs for several years.

Plant foods like legumes and dried fruits contain iron. Iron is also obtained through meat, fish and poultry products. Iron bio-availability is poor from plant foods but is good from animal foods. Fruits rich in vitamin C like gooseberries (amla), guava and citrus fruits improve iron absorption from plant foods. Beverages like tea bind dietary iron and make it unavailable. Hence, they should be avoided before, during or soon after a meal. Iron intake from diets is around 18 mg as against 35 mg RDA. An iron supplement (60 mg elemental iron, 100 mg folic acid) is recommended for 100 days during pregnancy from 16 week onwards to meet the demand of pregnancy.

Ques- How can one prevent Nutritional Anaemia? Or What are the rich sources of iron?

Ans-

- ✓ Non-vegetarian dietary sources of iron are red meat, fish, liver, and egg yolks; vegetarian sources include breastmilk, lentils and beans, whole grains and products made from these foods.
- ✓ Sprouting grains and beans enhance the bioavailability of the iron they contain, as does consuming iron-rich foods with "enhancers" - foods that contain vitamin C.
- ✓ Iron inhibitors, such as tannin and caffeine, and some essential minerals, prevent iron from being absorbed and should be consumed separately from iron sources.
- ✓ Jaggery (gur) instead of sugar is included, as it contains iron whereas sugar contains only a trace.

Ques- How is iron-deficiency anaemia related with parasitic infestation?

Ans-

- ✓ Much iron is lost through parasitic infestation.
- ✓ The best way to avoid getting intestinal parasites is to wash hands frequently and always after using the toilet and before eating food, using soap and safe water. Dishes, eating utensils and pots and pans, as well as vegetables and fruits must be thoroughly washed, and cleaned, and if necessary treated with disinfectant, and stored in hygienic conditions.
- ✓ Keeping the environment clean and free from excreta (human and animal) is also important to prevent parasites.
- ✓ Living areas should be swept and washed regularly, and latrines used by all members of the family. Animals should be kept in separate, preferably fenced areas, to avoid contamination where children are likely to play, especially on or near the ground.
- ✓ In areas with high rates of parasitic infestation, deworming should be carried out on a regular basis (at least every six months; more frequently if necessary.)

- ✓ Deworm children over 1 year or 2 years biannually

Ques- What are the signs and symptoms of Iron deficiency anaemia/

Ans-Symptoms and Signs of Anaemia

- pale skin, lips, tongue and inner surface of eyelids (conjunctiva)
- fatigue
- irritability
- weakness
- shortness of breath
- low blood pressure with position change from lying or sitting to standing (orthostatic hypotension)
- sore tongue
- brittle nails, concave nails
- unusual food cravings (called pica)
- decreased appetite (especially in children)
- headache - frontal
- low haematocrit and haemoglobin in a RBC
- low serum ferritin (serum iron) level

Ques- What are the Consequences of Nutritional Anaemia?

Ans-• Impaired cognitive performance at all stages of life

- Significant reduction of physical work capacity and productivity
- Increased morbidity from infectious diseases
- Greater risk of death of pregnant women during the perinatal period
- Negative foetal outcome: intrauterine growth retardation, low birth weight, prematurity

Ques- Can severe iron Deficiency Anaemia be treated with only dietary improvement?

Ans- Identification of the cause of deficiency is essential. Iron deficiency, especially severe deficiency, is serious and even life-threatening. Usually, it cannot be overcome by increasing dietary intake alone. Iron

Supplements, along with improved diet and eating habits, healthier hygiene and sanitation practices, deworming, and other solutions are nearly always required. Oral iron supplements are in the form of ferrous sulfate.

The best absorption of iron is on an empty stomach, but many people are unable to tolerate this and may need to take the supplement with food.

Milk and antacids containing calcium may interfere with absorption of iron and should not be taken at the same time as iron supplements.

Taking vitamin C supplements or eating vitamin C-rich foods at the same time as iron supplements can increase absorption and is essential in the production of haemoglobin. Iron supplements are needed during pregnancy and lactation because normal dietary intake cannot supply the required amount for the mother and the growing foetus.

The haematocrit should return to normal after 2 months of daily iron supplementation, but the iron tablets should be continued for another 6 to 12 months to replenish the body's iron stores, contained mostly in the bone marrow.

Ques- What are the causes of anaemia in women?

Ans- • Insufficient quantity of iron-rich foods and “iron enhancers” in the diet (foods rich in vitamin C such as citrus fruits), and low bioavailability of dietary iron (e.g. foods containing only non-heme iron)

- Excessive quantity of “iron inhibitors” in diet, especially during mealtimes (e.g. tea, coffee; calcium- rich foods)
- Iron loss during menstruation
- Poor iron stores from infancy and childhood deficiencies
- Iron loss from post-partum haemorrhage
- Increased iron requirement due to tissue, blood and energy requirements during pregnancy, and in some areas, due to heavy workloads
- Teenage pregnancy
- Repeated pregnancies with less than 2 years’ interval
- Iron loss due to parasite load (e.g. malaria, intestinal worms)
- Poor environmental sanitation, unsafe drinking water and inadequate personal hygiene causes of anaemia in children

Ques- What are the causes of anaemia in children?

Ans-

- Low iron stores at birth due to anaemia in mother
- Early introduction of inappropriate, non-fortified substitutes of breast milk
- Non-exclusive breastfeeding and too early introduction of inappropriate complementary food (resulting in diminished breast milk intake, insufficient iron intake, and heightened risk of intestinal infections)
- Late introduction of appropriate (iron-rich) complementary foods
- Insufficient quantity of iron and iron enhancers in diet, and low bioavailability of dietary iron (e.g. non-heme iron)¹
- Increased iron requirements related to rapid growth and development during infancy and childhood, until adulthood; and, in some areas, heavy physical workloads
- Iron loss due to parasite load (e.g. malaria, intestinal worms)
- Poor environmental sanitation, unsafe drinking water and inadequate personal hygiene

Ques- How can one treat severe iron deficiency anaemia?

Ans-Women with haemoglobin levels below 7 g/dl are considered to be severely anaemic.

Recommended therapeutic dose for women in the reproductive age group is one tablet (big) of iron thrice daily for a minimum of 100 days. This will provide equivalent to 180 mg elemental iron and 1500 µg folic acid per day. In case of 100 mg elemental folifer tablets, recommended dose is two (big) tablets of iron daily for a minimum of 100 days.

Further, cases of severe anaemia should be referred to the PHC medical officers for diagnosis of the causative factors and treatment.

Ques-What are the effects of maternal malnutrition on breast-milk?

Breast-milk provides good quality proteins, fat, vitamins, calcium, iron and other minerals even beyond four months. Zinc and iron from breast-milk are better absorbed than from other food sources.

What functions do these nutrients and special factors in vegetables/fruits perform in our body?

Iron

Iron is an essential element necessary for the formation of haemoglobin, the red pigment present in the red cells of blood. Haemoglobin plays an important role in the transport of oxygen to the tissues. Reduction in haemoglobin in blood leads to anaemia, a condition characterised by paleness and easy fatigue and increased susceptibility to infections. Iron is available in plenty in green leafy vegetables. But the absorption of iron is limited. Vitamin C rich foods must be consumed daily to improve iron absorption. Vitamin C is an essential nutrient required for healthy bones and teeth. It also promotes iron absorption.

Ques- How much food should be consumed to fulfil the daily requirements of iron?

Ans-The Expert Committee of the Indian Council of Medical Research, taking into consideration the nutrient requirements, has recommended that every individual should consume at least 300 g of vegetables (GLV : 50 g; Other vegetables : 200 g; Roots & Tubers : 50 g) in a day. In addition, fresh fruits (100 g), should be consumed regularly. Since requirements of iron and folic acid are higher for pregnant women they should consume 100g of leafy vegetables daily. High calorie vegetables and fruits to be restricted for overweight/ obese subjects.

Ques- Discuss the types of dietary iron present in our food?

Ans- Food iron is classified as either haem iron (the iron from meat, poultry and fish), or nonhaem iron (from cereals, pulses, legumes, fruits and vegetables).

Ques- What is Haem-iron and what are its sources?

- Haem iron is a constituent of haemoglobin and myoglobin and therefore is present in meat, fish and poultry, as well as in blood products.
- Haem iron accounts for a relatively small fraction of total iron intake –usually less than 1-2mg of iron per day, or approximately 10-15% of the dietary iron consumed in industrialized countries.
- Haem iron is readily available (20-30% absorption).

Ques-What is Non-Haem iron?

Ans-The second type of dietary iron, non-haem iron, is a more important source; it is found to vary degrees in all foods of plant origin.

Ques- Are there any other sources of iron in our diet?

Ans- Yes, besides the iron derived from food, the diet may also contain exogenous iron originating from the soil, dust, water or cooking vessels. This is more frequently the case in developing countries, where the amount of such contamination iron in a metal may be several times greater than the amount of food iron. The cooking of foods in iron pots may increase the iron content of a meal several folds. This is especially true for soups containing vegetables of low pH which are simmered for a long time. Frying in iron pans does not usually increase the food's iron content. Any iron released during cooking is integrated into the non-haem iron pool and is available for absorption.

Ques-What are the sources of dietary haem and non-haem iron?

Ans-

CHEMICAL FORM AND TYPE OF IRON	SOURCE
Haem iron	Meat, fish, poultry and blood products. Accounts for 15 % of iron intake in industrialized countries. Usually represents less than 10% of total intake (often negligible amounts) in developing countries. Bioavailability high absorption 20-30%
Non-Haem iron -food iron	Mainly found in cereals, tubers, vegetables and pulses. Bioavailability determined by the presence of enhancing and inhibiting factors consumed in the same meal
-contamination iron	Soil, dust, iron pots, etc. potential bioavailability usually low. May be present in large quantities, in which case its contribution to total iron intake is not insignificant.

Ques-What are the major determinants of iron absorption?

Ans-The absorption of dietary iron is influenced by the amount and chemical form of the iron, the consumption during the same meal of factors enhancing and /or inhibiting iron absorption, and the health and iron status of the individual.

Factors that enhance non-haem iron absorption:

-ascorbic acid (vitamin C)

-meat, poultry ,fish and other seafood -low pH (e.g., lactic acid)
Factors that inhibit non-haem iron absorption: -phytates -polyphenols, including tannins
Host Factors: -iron status Health status (infections, malabsorption)

Ques- How much vitamin C/Ascorbic acid should be included in the diet for improving dietary iron absorption?

Ans- Adding as little as 50mg of ascorbic acid to a meal, whether impure form or in vegetables or fruits (for example, an orange or a lemon, or 100 g of cabbage, or 200 g of amaranth)., will double iron absorption.

Ques-Are there any compounds in our diet which inhibit dietary iron absorption?

Ans-Many compounds are known to inhibit the absorption of iron, among them phytates, polyphenols (including tannins)., and soy proteins.

- Soy proteins can impair iron absorption under certain circumstances specially when it is used as a meat substitute. However, because of the intrinsically high iron content of soy protein products, the net effect of their addition to a meal is to increase, rather than decrease, the total amount of iron absorbed.
- Phytates are present in wheat and other cereals. Even very small amounts of phytates markedly reduce iron absorption. Fortunately this inhibitory effect can be counteracted with ascorbic acid.
- Tannins, which are present in tea and to a lesser extent in coffee, are also iron absorption inhibitor. Other polyphenols are found in nuts and legumes. Once again, the inhibitory effect of all polyphenols can be counteracted by adding ascorbic acid to the meals.

Ques- What about tea and coffee?

Ans- Tannin is also present in tea and coffee and is known to interfere with iron absorption. , tea and coffee should be avoided at least for one hour before and after meals. Polyphenols in tea are strong inhibitors of iron absorption.

For example, one large cup (250 ml) of black tea can inhibit non-haem iron absorption by approximately 50 percent even when drunk one hour after consuming the meal; it has no

effect, however, when consumed between meals. This inhibition is strongly dose-related. The inhibiting effects can be reduced to some extent by serving tea with lemon or adding sufficient milk (100 ml) to the cup of tea.

Tea with milk, lemon tea or herbal tea has been included between meals (and not with them) for better iron absorption from the meals.

Ques- Is Iron absorption is related to the individual's iron status?

Ans Yes, more iron is absorbed by iron-deficient persons and less by those who are iron-replete, although the regulatory mechanism involved is not understood. Unfortunately this adaptive increase in iron absorption is not great enough to prevent deficiency in people consuming diets typically of the developing world.

Ques- What are the clinical signs and symptoms of iron deficiency anaemia?

Ans-The signs and symptoms of anaemia-pallor of the skin and of the conjunctiva, fatigue, shortness of breath, lack of appetite.

Ques- What is the current prevalence of Iron Deficiency Anaemia?

Ans-Available studies on prevalence of nutritional anemia in India show that 65% infant and toddlers, 60% 1-6 years of age, 88% adolescent girls (3.3% has hemoglobin < 7 gm./dl; severe anemia) and 85% pregnant women (9.9% having severe anemia). The prevalence of anemia was marginally higher in lactating women as compared to pregnancy. The commonest is iron deficiency anemia.

Ques- When was National Nutrition Anemia Prophylaxis Programme started?

Ans- The programme was launched in 1970 to prevent nutritional anemia in mothers and children. Under this programme, the expected and nursing mothers as well as acceptors of family planning are given one tablet of iron and folic acid containing 60 mg elementary iron which was raised to 100 mg elementary iron, however folic acid content remained same (0.5 mg of folic acid) and children in the age group of 1-5 years are given one tablet of iron containing 20 mg elementary iron (60 mg of ferrous sulphate and 0.1 mg of folic acid) daily for a period of 100 days. This programme is being taken up by Maternal and Child Health (MCH), Division of Ministry of Health and Family Welfare. Now it is part of RCH programme.

Ques- What are the New guidelines on Iron and Folic Acid supplementation?

Ans-As stated in Review of the policy regarding micronutrients- iron and folic acid (IFA)-2007

- The infants between 6-12 months should also be included in the programme as there is sufficient evidence that iron deficiency affects this age group also
- Children between 6 months to 60 months should be given 20 mg elemental iron and 100 micro gm folic acid per day per child as this regimen is considered safe and effective.

- For children 6 months to 60 months, ferrous sulphate and folic acid should be provided in a liquid formulation containing 20 mg elemental iron and 100 mg folic acid per ml of the liquid formulation. For safety reasons the liquid formulations should be dispersed in bottles so designed that only 1ml can be dispersed each time.
- School children, 6-10 year old, and adolescents 11-18 year olds, should also be included in the National Nutrition Anaemia Prophylaxis Programme (NNAPP)
- Children 6-10 year-old will be provided 30mg elemental iron and 250 mcg folic acid per child per day for 100 days in a year.
- Adolescents, 11-18 years will be supplemented at the same doses and duration as adults. The adolescent girls will be given priority.
- The newer products such as double fortified salts/sprinklers /ultra rice as other micronutrient candidates or fortified candidates should be explored as an adjunct or alternate supplementation strategy.

Ques- What is Weekly Iron and Folic Acid Supplementation Programme for adolescents?

Ans- The Government has decided to implement the Weekly Iron and Folic Acid Supplementation (WIFS) Programme for adolescents. WIFS Programme is based on the empirical evidence that weekly supplementation of 100mg Iron and 500µg Folic acid is effective in decreasing prevalence of anaemia in adolescent age group.

The programme is free of cost and Iron and Folic Acid deworming tablet, along with testing and counselling services would be provided completely free.

Ques-Who are the beneficiaries under this programme?

Ans-The programme will be implemented in both rural and urban areas and will cover school going adolescent girls and boys (10-19 years) from 6th to 12th class enrolled in government/government aided/municipal schools through the platform of Schools and out of school adolescent girls through the platform of Aganwadi centers.

Ques-How will this programme be implemented?

Ans-Modalities of implementation are as below:

- Administration of supervised free Weekly Iron-folic Acid Supplements of 100mg elemental iron and 500µg Folic acid to target population.
- Fixed day strategy under which preferably Monday to be declared as “Anaemia Control day” or “WIFS day”.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthes infestation.

- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.
- Convergence with key stakeholder Ministries like Ministry of Women and child Development and Ministry of Human Resource Development.

Ques- What is the prevalence of Anaemia in adolescents?

Ans-Adolescent Anaemia has been a long standing problem in India and the country has a high prevalence. However, there has been a 5% decline in incidence of anemia amongst adolescents between National Family Health Survey (NFHS)-II (1998-99) and National Family Health Survey (NFHS)-III (2005-06).

The prevalence of anaemia (Haemoglobin value of <12 g% in girls and Haemoglobin value of < 13g% in boys) is high amongst adolescents as per the report of NFHS-III and the National Nutrition Monitoring Bureau Survey.

It is estimated that more than 5 Crores adolescents are anaemic in India.

According to NFHS -III data, over 55 % of adolescent boys and girls in the age group of 15-19 years are anaemic.

Ques-Why Adolescent girls are more vulnerable to anaemia than adolescent boys?

Ans- Adolescent girls in particular are more vulnerable to anaemia due to the rapid growth of the body and loss of blood during menstruation. According to NFHS-III, almost 56% of adolescent girls aged 15-19 years suffer from some form of anaemia. Of these, 39% are mildly anaemic while 15% and 2% suffer from moderate and severe anaemia respectively. In India, the highest prevalence of anaemia is reported between the ages 12-13 years, which also coincides with the average age of menarche. With increase in age, the prevalence of anaemia among girls remains almost stagnant, while among boys, the prevalence rate reduces.

Ques- What are the reasons for anaemia amongst adolescents?

Ans- The reasons for anaemia amongst adolescents are:

- Growth spurt leading to increased demand of Iron in the body
- Poor dietary intake of Iron
- Worm infestation and high rate of infection
- Increased loss of Iron due to onset of menstruation (in girls)

Ques- What are the level of anaemia (cut-offs)?

Ans-Mild (10.0-10.9 g/dl)
 Moderate (7.0-9.9 g/dl)
 Severe (<7.0 g/dl)
 Any anaemia (<11.0 g/dl)

Ques- How MDM helps in reducing Anaemia?

Ans- As per MDM Guidelines Green leafy vegetables should be added in the Mid day meal menu so that the children should get the nutritional benefits and one portion of the iron of the day can be fulfilled.

Under the Scheme cooked mid day meal with 450 calories and 12 grams of protein is provided to every child at Primary level and 750 calories and 20 grams of protein at Upper Primary level. This energy and protein requirement for a primary child comes from cooking 100 gms of rice/flour, 20 gms pulses and 50 gms vegetables and for an upper primary child comes from 150 gms of rice/flour, 30 gms of pulses and 75 gms To address hunger in schools by serving hot cooked meal, with the following objectives.

It is well accepted that vegetables are a vital part of a balanced diet. They are good sources of a range of vitamins, minerals, phytochemicals and dietary fibre and they play an important role in preventing and controlling micronutrient deficiencies, including deficiencies in vitamin A, B (folate), C and E. Vegetables owing to their high natural vitamin C content, can also alleviate iron deficiency by boosting the absorption Yellow/orange fruits and vegetables, (e.g. carrots, pumpkin, papaya and ripe mangoes) and dark-green leafy vegetables, including indigenous vegetables, are rich in provitamin A carotenoids, which human body can convert into the active form of vitamin A provided there is adequate fat in the diet.

TABLE FOOD GROUP FOOD IRON, mg/100 g CONTAINED IN RAW EDIBLE PORTION

Food	IRON, mg/100 g CONTAINED IN RAW EDIBLE PORTION
Cereals and millets	
Bajra (Indian millet, <i>Pennisetum typhoideum</i>)	8.0
	9.3
Samai (little millet, <i>Panicum miliare</i>)	35.0
Rice bran	6.0
Wheat germ	
Pulses and legumes	
Soybean	10.4
	9.5
Chickpea, roasted	8.6
Cowpea	7.6
	7.1
Lentil	6.8
Peas, dry	
Horse-gram (<i>Dolichos biflorus</i>), whole	
Green leafy vegetables	
Amaranth, beet, cauliflower, chekkur manis, chickpea, cowpea, manathakkali, mint, mukarrate keerai, mustard, parsley, radish, shepu, turnip	15.6–40
Other vegetables	
Lotus stem, dry	60.6
	39.1
Karonda, dry	22.2
Sundakai, dry	7.4
Onion stalks	6.3
Plaintain greens	

Nuts and oil-seed	
Garden cress seeds	100.0
Coconut meal, deoiled	69.4
Niger seeds	56.7
Gingelly seeds	9.3
Mustard seeds	7.9
Dry fruits	
Pistachio nuts	7.7
Blackcurrants	8.5
Dates	7.3
Condiments and spices	
Turmeric	67.8
Mango powder	45.2
Tamarind pulp	17.0
Poppy seeds	15.9
Black pepper, cloves, cumin	12.0
SOURCE: Gopalan <i>et al.</i> , 1989	

Ques-What are the Recommended Dietary allowances (RDA) for Iron for different age groups for Indians?

Ans-ICMR, 2010 suggests the following RDA

Group	Age	Body Weight (Kg)	RDA (mg/day)
Men		60	17
Women (NPNL)		55	21
Pregnant women		55 (pre-pregnancy wt.)	35
Lactating women		55	21
Infants	0-6m	5.4	46µg/kg/d
	6-12 m	8.4	05

Children	1-3 yrs	12.9	09
	4-6	18.0	13
	7-9 yrs	25.1	16
Boys	10-12 y	34.3	21
Girls	10-12 y	35.0	27
Boys	13-15 y	47.6	32
Girls	13-15 y	46.6	27
Boys	16-17 y	55.4	28
Girls	16-17 y	52.1	26

Combinations and proportions of foods for daily consumption to enhance iron bioavailability: example number 1

MEAL	MENU	FOOD, RAW EDIBLE PART (g)
Early morning	Tea with milk/lime or herbal tea + biscuits (two) or rusk (one)	150 + 50/10 or 150
	Sugar	5
Breakfast	Stuffed chapatti or parantha Wheat + potato (boiled)	100 + 75
	Curd (like yoghurt) or milk	100
Lunch	Wheat + millet flours + cauliflower chapatti	50 + 50 + 50
	Lentil dal	30
	Cabbage, raw + tomato + lime juice salad	25 + 30 + 15
	Jaggery + gingelly seeds <i>gajak</i>	10 + 10
Mid-afternoon	Tea with milk/lime or herbal tea	150 + 50/10 or 150
	Sugar	5
	Snack (sweet or savoury), 1 or 2 pieces or equivalent	
Dinner	Rice <i>khichdi</i> :	
	Rice parboiled +	100
	Green gram split +	30
	Amaranth leafy vegetables	75
	Onion stalks	50
	Guava, orange or papaya	50