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ABSTRACT: Intermittent water supply (IWS) is prevalent throughout low and middle-income countries. IWS is associated with increased microbial contamination and potentially elevated risk of waterborne illness. We used existing data sets to estimate the population exposed to IWS, assess the probability of infection using quantitative microbial risk assessment, and calculate the subsequent burden of diarrheal disease attributable to consuming fecally contaminated tap water from an IWS. We used reference pathogens Campylobacter, Cryptosporidium, and rotavirus as conservative risk proxies for infections via bacteria, protozoa, and viruses, respectively. Results indicate that the median daily risk of infection is an estimated 1 in 23 500 for Campylobacter, 1 in 5 050 000 for Cryptosporidium, and 1 in 118 000 for rotavirus. Based on these risks, IWS may account for 17.2 million infections causing 4.52 million cases of diarrhea, 109 000 diarrheal DALYs, and 1560 deaths each year. The burden of diarrheal disease associated with IWS likely exceeds the WHO health-based normative guideline for drinking water of 10^-6 DALYs per person per year. Our results underscore the importance water safety management in water supplies and the potential benefits of point-of-use treatment to mitigate risks.

INTRODUCTION

An intermittent water supply (IWS) is a piped water supply that delivers water to end-users on a discontinuous basis, with days or hours of interruption, due to operational constraints including inadequate access to water and energy, distribution system deficiencies, pipe breakages, poor governance or other issues.1 IWS is prevalent in many low and middle-income countries (LMICs).2 From 2004 to 2013, the International Benchmarking Network (IBNET), documented water supply lasting less than 24 h per day in 44 of the 102 countries included in the database.3 In 2000 the World Health Organization (WHO) estimated that 60% of the population served by piped water in Latin America and the Caribbean were served by IWS4 and that at least one in three urban water supplies in Africa and one in two in Asia operated intermittently.5 The rapid development of piped water supplies in LMICs, especially in rural and peri-urban areas,6 climate change,7 and urbanization, together exert increasing pressure on the resources required to maintain piped water supply functionality, and suggests that the population served by IWS could increase significantly in the coming years.

Users of IWS are exposed to increased health risks because such supplies are subject to increased microbial contamination through the intrusion of environmental water from outside the pipeline during low-pressure events, microbial regrowth during stagnant periods, biofilm scouring during repressurization, and household storage in response to unreliable supply.6,9 As summarized in Supporting Information (SI) Table S1, the available evidence suggests large variability in the prevalence of fecal contamination in IWS networks with the proportion of samples positive for fecal coliforms ranging from 4% to 32%. Quantitative studies of fecal indicators also suggest high variability in measures of central tendency and counts ranging over several orders of magnitude:

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E. coli from 0.5 MPN/100 mL to 520 CFU/100 mL and fecal coliform from 4 CFU/100 mL to 175 CFU/100 mL (SI Figure S1). In the only study documenting E. coli counts in an IWS compared with a continuous water supply (CWS), 31.7% of samples in the IWS were positive for E. coli while only 0.7% of samples were positive for E. coli in the CWS. A majority of studies documenting microbial contamination in IWS networks are cross-sectional and of small sample size and therefore fail to adequately document the temporal variability of microbial water quality in an IWS. Nonetheless, the best available data indicate that fecal contamination is frequently detected in IWS tap water and that contamination prevalence is likely to be much greater in an IWS compared to a CWS.

Maintenance of adequate disinfectant residual is essential to reduce the risks of contamination during distribution. Low disinfectant residuals are often observed in LMICs, however, potentially increasing risks associated with IWS. Fecal contamination in an IWS has been associated with epidemics of typhoid in Tajikistan and cholera in Peru. However, endemic gastrointestinal illness (GII) associated with IWS has proven harder to detect. In a meta-analysis, Ercumen et al. concluded that users of IWS had 1.61 times greater odds of GII compared to those that were served by a CWS (OR = 1.61, 95% CI: 1.26–2.07). More recent studies of IWS and GII have yielded mixed results, with one finding no association between IWS and diarrhea and another finding an association between cholera incidence and supply intermittency. The current epidemiological evidence, summarized in SI Table S2, suggests that intermittent supply has been associated with epidemic transmission of waterborne diseases such as cholera and typhoid, but statistically meaningful associations between IWS and endemic GII are more difficult to establish.

Given the global prevalence of IWS, the observed fecal contamination in such supplies, and the absence of clear epidemiological evidence concerning the endemic health risks associated with IWS, quantitative microbial risk assessment (QMRA) offers a potentially useful tool for characterizing the risk of infection for fecal-oral pathogens associated with IWS and the attributable burden of diarrheal disease. QMRA can make use of relevant microbiological data sets alongside mathematical models to estimate the health effects of human exposures to pathogens. QMRA has been used to estimate the health risks associated with drinking water for a number of waterborne pathogens including viruses, bacteria, and protozoa, and for a variety of exposure scenarios, including intrusion of groundwater, surface water, and sewage. The application of QMRA in LMICs has been limited by scarcity of the data required to populate models. However, QMRA approaches have been used to estimate public health risks attributable to piped water supplies in Kampala, Uganda, and Accra, Ghana. Such studies demonstrate the viability of the approach and its importance in risk management in resource limited settings such as those where IWS is prevalent. In this paper, we use QMRA to estimate the global burden of infection, morbidity, and mortality associated with IWS.

**MATERIALS AND METHODS**

We used Monte Carlo techniques to estimate the risks of infection associated with human exposures to three reference pathogens (*Campylobacter*, *Cryptosporidium*, and rotavirus) through the consumption of fecally contaminated tap water delivered by an IWS. We made use of three existing data sets: *E. coli* measurements in IWS tap water samples, measured pathogen to *E. coli* ratios in sewage, and published dose–response models to estimate the risk of infection. We fit probability distributions to each input data set and executed Monte Carlo simulations in Oracle Crystal Ball software.

We then used the predicted median annual risk of infection for each reference pathogen and an estimate of the number of IWS users to quantify a global burden of diarrheal disease, including disability adjusted life years (DALYs) and deaths, associated with IWS. This manuscript is organized using the conventional QMRA framework consisting of hazard identification, exposure assessment, dose–response and risk characterization. The framework for the risk assessment model as we implemented it is illustrated in Figure 1.

**Hazard Identification.** In the absence of published measurements of waterborne pathogens in an IWS, we utilized a reference pathogen approach. We selected *Campylobacter jejuni*, *Cryptosporidium parvum*, and rotavirus as reference pathogens, following the model development guidance articulated in the WHO Guidelines for Drinking-water Quality (GDWQ) and supporting documentation. While these reference pathogens may not represent the greatest microbial drinking water exposure risks globally, they can be used as conservative proxies for each of the major waterborne pathogen classes in risk estimation. They also have well-characterized dose–response relationships, moderate to long persistence in

![Figure 1. A schematic of the Monte Carlo framework used to estimate the daily probability of infection for Campylobacter, Cryptosporidium, and rotavirus assuming the consumption of fecally contaminated tap water from an IWS.](image-url)
Campylobacter is a pathogenic bacterium that has caused disease outbreaks associated with contaminated drinking water supplies. It has a low infectious dose with symptoms including diarrhea, fever, nausea, and vomiting, with rare sequelae (Guillain-Barré syndrome). Cryptosporidium is a protozoan parasite that has caused large outbreaks of disease through transmission in piped water supplies. The infectious dose of Cryptosporidium has been estimated to be as low as 1 to 10 oocysts with most infections leading to acute diarrhea, with increased risks of serious illness and death among immunocompromised individuals. Although commonly associated with hygiene-related transmission, rotavirus has caused significant waterborne disease outbreaks in Rio de Janeiro, Colorado, and China. One rotavirus particle is capable of initiating an infection leading to fever, vomiting, and acute diarrhea and, in low income settings, presents a significant risk of death among children. The selection of Campylobacter, Cryptosporidium, and rotavirus as reference pathogens is supported by findings from the Global Enteric Multicenter (GEMS) Study and a multisite birth cohort study (MAL-ED) that identified each of them as important etiological agents of moderate-to-severe cases of diarrhea among children under 5 in LMICs.

Dose–Response. The probability of infection following ingestion of a dose of Campylobacter or rotavirus is best fit by a Beta-Poisson function, characterized by the median infectious dose, N50, the Beta distribution parameter alpha, α, and the dose, d. Probability of infection for ingesting Cryptosporidium is best characterized by an exponential dose–response function, eq 2, described by parameters k, and the ingested dose, d. For each reference pathogen, we used the dose response parameters from previously published dose–response fittings and modeled them using log-normal probability density functions (PDF) as described in Table 1.

We modeled water consumption in milliliters (Vwater consumed, IWS) as a uniform PDF with a minimum of 1000 per day and maximum of two thousand per day based on the use of one liter per day in WHO risk estimates and two liters per day for adult drinking water consumption in the United States. To estimate the PDF for the concentration of each reference pathogen in the absence of direct measurements of pathogens in IWS tap water, we used a previously developed method of quantifying waterborne pathogens in water distribution networks using pathogen to E. coli or thermotolerant coliform ratios. In this approach, the number of pathogens per volume of drinking water is calculated by multiplying the concentration of E. coli measured in IWS tap water by the observed ratio of pathogen to E. coli in a potential source of fecal contamination, in this scenario sewage, as shown in eq 4.

<table>
<thead>
<tr>
<th>pathogen</th>
<th>dose–response parameter</th>
<th>distribution</th>
<th>distribution description</th>
<th>reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>α</td>
<td>lognormal</td>
<td>mean: 1.51 × 10⁻¹ std. dev.: 5.90 × 10⁻²</td>
<td>33,44</td>
</tr>
<tr>
<td></td>
<td>N50</td>
<td>lognormal</td>
<td>mean: 1.69 × 10⁷ std. dev.: 2.78 × 10⁶</td>
<td>4</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>k</td>
<td>lognormal</td>
<td>mean: 3.44 × 10⁻¹ std. dev.: 2.02</td>
<td>4</td>
</tr>
<tr>
<td>rotavirus</td>
<td>α</td>
<td>lognormal</td>
<td>mean: 2.46 × 10⁻¹ std. dev.: 1.46 × 10⁻¹</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>N50</td>
<td>lognormal</td>
<td>mean: 8.16 std. dev.: 6.65</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 1. Descriptive Statistics of the Probability Density Functions Used to Model Each Stochastic Parameter in the Monte Carlo Simulation**

<table>
<thead>
<tr>
<th>parameter</th>
<th>distribution</th>
<th>distribution description</th>
<th>reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>tap water consumption</td>
<td>uniform</td>
<td>min: 1 L max: 2 L</td>
<td>27,49</td>
</tr>
<tr>
<td>log E. coli count in IWS tap water</td>
<td>normal</td>
<td>mean: 0.17 std. dev.: 1.57</td>
<td>10,51,52</td>
</tr>
<tr>
<td>Campylobacter to E. coli ratio in sewage</td>
<td>lognormal</td>
<td>mean: 8.89 × 10⁻³ std. dev.: 1.33</td>
<td>55</td>
</tr>
<tr>
<td>Cryptosporidium to fecal coliform ratio in sewage</td>
<td>lognormal</td>
<td>mean: 1.13 × 10⁻⁶ std. dev.: 9.26 × 10⁻⁶</td>
<td>54</td>
</tr>
<tr>
<td>rotavirus to fecal coliform ratio in sewage</td>
<td>lognormal</td>
<td>mean: 8.79 × 10⁻⁷ std. dev.: 1.77 × 10⁻⁷</td>
<td>54</td>
</tr>
</tbody>
</table>
We developed a PDF of the E. coli count in IWS tap water using data from three studies of fecal contamination in IWS systems in three locations: Kandal Province, Cambodia; Da Nang Province, Vietnam; and Hubli-Dharwad, India. These studies were selected because of their large sample size and use of robust methods to quantify E. coli. We log transformed the E. coli counts and used maximum likelihood techniques to parametrize the normal distribution that maximized the likelihood of obtaining the observed values. For values below detection limits, we used the value of the cumulative likelihood of obtaining the observed values. For values below and above detection limits, we used the value of the cumulative normal distribution function to incorporate these censored measures into the maximum likelihood estimation (MLE) per previously described methods. We estimated the log transformed E. coli counts to be normally distributed with mean of 0.17 and standard deviation of 1.57 as shown in Table 1. Boxplots of log E. coli counts from each study, the pooled data set, and the MLE model (SI Figure S2) show that the quartiles, median, and mean of the underlying data compare well with the modeled distribution. The frequency and cumulative distributions (SI Figures S3 and S4) indicate that the MLE model of the E. coli count is comparable to the underlying field observed E. coli distributions.

For the second term of eq 4, we developed PDFs of the ratio of each reference pathogen to E. coli in raw sewage using paired measurements from sewage. Paired measures from sewage sources specific to locations where IWS is prevalent could not be found in the literature, so we used observations from a sewage treatment plant in The Netherlands (ratio of Cryptosporidium and enterovirus to thermotolerant coliforms) and German sewer systems (ratio of Campylobacter to E. coli). Since robust measurements of thermotolerant coliform measurements in IWSs were unavailable in the literature, we assumed that 95% of thermotolerant coliforms in the measured ratios were E. coli. Additionally, we substituted rotavirus for enterovirus in the observed ratio. We used the previously described MLE technique on the log transformations of the observed ratios to parametrize the normal distribution that maximized the likelihood of observing the documented measures. The probability distributions and parameters for the reference pathogen to E. coli ratios in are summarized in Table 1.

Risk Characterization. To test the mathematical framework and plausibility of the proposed model, we first made point estimates of the daily and annual risk of infection, and the subsequent diarrheal burden of disease. After we reviewed the point estimates, we entered each stochastic variable using the PDFs as described and conducted Monte Carlo simulations in Crystal Ball. Each variable was drawn 10 000 times per the PDF that describes it and each individual input was propagated through the described equations to produce a distribution of the daily probability of infection. We estimated the median, mean, their associated confidence intervals, and percentiles of the probability of infection by bootstrapping the model with 200 samples of 1000 trials each. We evaluated the sensitivity of the estimated risks of infection to changes in the input variables by means of tornado analysis and rank correlation. In the tornado analysis, we varied each input from its 10th to 90th percentile and measured the associated variability in the predicted risk of infection while holding all other inputs constant. Rank correlation was determined using Spearman’s rank correlation between each input variable and the predicted risk of infection.

Population Served by IWS Estimate. We made a robust estimate of the population served by IWS by projecting the IBNET reported prevalence of intermittent service onto JMP measures of access to piped-on-premise water supplies. The IBNET database contains more than 22 000 records from 119 countries dating from 1995 to 2014. Each record consists of a single utility’s self-reported performance data for a single year. For this analysis, we used only the most recent record from any single utility that contained both the number of hours the utility supplied water per day and the number of people it supplied. To exclude supply interruptions for repairs and maintenance associated with normal operations in a CWS, we defined an IWS as a utility reporting less than an average of 23 h per day of service. We further limited our analysis to utilities reporting from countries defined as LMICs by the World Bank. After we removed records that were incomplete, outdated, or from high income countries, 2591 records pertaining to utilities serving over 773 million people in 91 LMICs were included in the analysis (SI Figure S5). After screening, we stratified utilities reporting IWS into WHO regions and calculated an average percentage of utilities in that region that were such. We then bootstrapped this average percentage using 10 000 iterations to estimate 95% confidence intervals for each region. We then calculated the average and 95% confidence interval for the global estimate similarly. To calculate the magnitude or persons infected by IWS for each WHO region and globally, we multiplied the estimated percentages and confidence intervals by the number of persons receiving their drinking water from a piped-on-premise supply for each WHO region per the 2015 JMP Update.

Burden of Disease Calculations. We combined the probabilities of infection for each reference pathogen with the estimated percentages and confidence intervals for each region. We then multiplied the estimated percentages and confidence intervals by the number of persons receiving their drinking water from a piped-on-premise supply for each WHO region per the 2015 JMP Update.
100 000 and equates to everyone experiencing one mild self-limiting case of diarrhea every 10 years due to the consumption of unsafe water.

Results and Discussion

Point Estimates of Infection Risks. We made point estimates of the daily and annual risk of infection, and the annual burden of diarrheal disease, for each reference pathogen using median values of the observed Campylobacter concentration in IWS tap water (1.3 CFU/100 mL) along with median values of the ratio of reference pathogen to E. coli in sewage, tap water consumption, and dose–response parameters. These point estimates indicate that, of the pathogens considered, Campylobacter poses the greatest risk of infection, possibly due to the greater ratio of Campylobacter to E. coli observed in sewage from Germany. As shown in SI Table S5, the ranking of pathogens untreated wastewater as documented in the Table 7.6 of the Campylobacter, 0.34% for simulations, summarized in Table 2, are consistent with the daily probabilities of infection predicted by the Monte Carlo burden of diarrheal disease for each reference pathogen exceeds simulations, summarized in Table 2, are consistent with the daily probabilities of infection predicted by the Monte Carlo burden of diarrheal disease for each reference pathogen, shown in SI Figures S6, S7, and S8, illustrate that the mean daily risk of infection for each reference pathogen was greater than the 80th percentile.

Monte Carlo Estimates of Infection Risks. The median daily probabilities of infection predicted by the Monte Carlo simulations, summarized in Table 2, are consistent with the point estimates with the highest risk associated with Campylobacter (4.26 × 10⁻³; 95% CI: 1.92 × 10⁻³ − 7.89 × 10⁻⁵) followed by rotavirus (8.47 × 10⁻⁶; 95% CI: 3.77 × 10⁻⁶ − 1.77 × 10⁻⁷) and Cryptosporidium (1.98 × 10⁻⁷; 95% CI: 8.31 × 10⁻⁸ − 3.71 × 10⁻⁷). These translate to median annual probabilities of infection of 1.54% for Campylobacter, 0.30% for rotavirus, and 0.007% for Cryptosporidium. The upper bounds of the daily probability of infection, as defined by the 90th percentile and shown in Table 2, were 25% for Campylobacter, 0.34% for Cryptosporidium, and 7.3% for rotavirus. The cumulative distributions of the daily probability of infection for each reference pathogen, shown in SI Figures S6, S7, and S8, illustrate that the mean daily risk of infection for each reference pathogen was greater than the 80th percentile.

For this reason, we used the median risks of infection and their associated confidence intervals to make a conservative calculation of the diarrheal burden of disease associated with the consumption of fecally contaminated tap water delivered by an IWS.

Model Sensitivity. For Cryptosporidium and rotavirus, most of the variation in the predicted risk of infection was explained by the E. coli count in IWS tap water (Cryptosporidium: 45.86%; rotavirus: 81.42%) followed by the pathogen to E. coli ratio (Cryptosporidium: 32.75%; rotavirus 9.79%). For Campylobacter, the opposite was observed with 85.44% of the variation explained by the Campylobacter to E. coli ratio followed by the E. coli count in IWS tap water with 8.52%. The dose response parameters for each pathogen explained most of the remaining uncertainty followed by the tap water consumption variable. The sensitivity analysis summarized in SI Tables S6, S7, and S8, highlights the importance of the E. coli counts in IWS tap water and the ratio of the reference pathogens to E. coli in estimating the risk of infection in the current assessment.

Global Population Served by IWS. Our preliminary estimate of the IWS population based on WHO reports and the 2015 JMP data, summarized in SI Table S9, found that approximately 1 billion people were likely exposed to IWS. The results of our more robust estimate made using IBNET and JMP data, listed in SI Table S10, indicate that the global population served by IWS is 925 million (95% CI: 670–1,130 million) with almost half (44.2%) of those exposed living in Southeast Asia and a significant number living in India (SI Figure S9).

Diarrheal Burden of Disease Calculations. The estimated population served by IWS and the median annual infection risks, the reference pathogens together account for 17.2 million (95% CI: 7.76–32.3) infections annually among IWS users. Of these infections, 83% are attributable to Campylobacter, 17% to rotavirus, and less than 1% to Cryptosporidium. These infections cause 4.52 million (95% CI: 2.04–8.36) cases of diarrhea annually with Campylobacter accounting for 95% of these cases while Cryptosporidium and rotavirus account for 1% and 4% each. These cases of diarrhea cause 109 000 DALYs (95% CI: 48 800–223 000) and 1560 deaths (95% CI: 699–3150) per year. Burden of disease estimates based on the median infection risks are summarized by WHO region in Table 3. Rotavirus accounts for 82.1% of annual diarrheal DALYs and deaths, while Campylobacter accounts for 18.1% of DALYs and deaths. In this exposure scenario, Cryptosporidium accounts for less than 1% of both annual DALYs and deaths among users of IWS. The burden of disease stratified by etiology is tabulated in SI Table S11. The predominance of rotavirus in the annual diarrheal disease burden is driven by its high DALY weighting in LMICs (0.482 per case) along with its high LMIC case fatality rate (0.6%). Campylobacter’s burden of disease is driven by its high risk of infection, 1 order of magnitude greater than rotavirus, and population susceptibility of 100%. While it is also assumed that 100% of the population is susceptible to diarrheal disease from Cryptosporidium infection, the median infection risk for the organism is 2 orders of magnitude less than that of Campylobacter.

The cumulative distributions of the annual burden of diarrheal disease for each reference pathogen, shown in SI Figures S6, S7, and S8, indicate that the annual burden for Campylobacter exceeds the WHO health threshold (10⁻⁶ DALYs/person-year) at the 39th percentile, Cryptosporidium...
at the 62nd percentile, and rotavirus at the 33rd percentile. The cumulative distributions of total diarrheal DALYs and deaths among the 925 million global users of IWS, shown in SI Figure S10, indicate that the upper bounds, as defined by the 90th percentile, are 30.9 million diarrheal DALYs and 394,000 deaths.

Uncertainties and Limitations. As with all QMRA approaches, there are uncertainties and limitations in the input variables that should be accounted for when interpreting the results. A significant source of uncertainty for our risk assessment is the absence of direct measurements of pathogen concentrations in IWS distribution networks. Without these measurements, across settings and time, we relied on estimated concentrations of reference pathogens by proxy using fecal indicator bacteria measurements and ratios of pathogens to indicators in possible sources of contamination. Concerning fecal indicator bacteria, we were only able to pool data from three high-quality studies conducted in India, Cambodia, and Vietnam. These studies represent a small portion of the geographical range of IWS, globally, and include no data from South America and sub-Saharan Africa. The E. coli data sets used in this analysis also do not include fist flush data when fecal indicator concentrations may be much higher. Further, the pooled data set consists of E. coli measurements from both urban and rural supplies, which prevents stratifying infection risk by urban and rural location, a potential risk factor for infection..

Concerning ratios of pathogens to indicators in potential sources of contamination, the correlation between pathogens and indicators in any medium have proven highly variable. In raw sewage, the concentration of indicator bacteria is fairly constant whereas the concentration of pathogens varies as a function of the infection prevalence in the contributing population. Thus, it is important to characterize the ratio using a distribution to capture this variability. There are few published data sets of pathogen to E. coli ratios in sewage particularly in LMIC; in this study, we derived ratios using data sets from The Netherlands and Germany. These data sets likely underestimate the pathogen loadings in sewage in LMICs where higher prevalence of diarrheal infection could result in increased pathogen concentrations relative to indicators in sewage.

Sources of uncertainty can also be found in the assumptions underlying exposure assessment. First, in the absence of untreated tap water consumption data from LMIC settings, we modeled daily tap water consumption as a uniform distribution from 1 to 2 L based on exposure scenarios articulated in EPA and WHO estimates. This probability distribution is not likely to be representative of water consumption behavior in settings where supplies are deficient and consumer behaviors include a complex system of household water management. Second, the scenario being modeled is the consumption of drinking water as it is delivered to the tap. This behavior is unlikely in an IWS where users, who are accustomed to supply interruptions, may obtain water from multiple sources and often store water in tanks, cisterns, and other containers for hours to days before the water is used. Household water handling and storage involve several risk factors for contamination, such as unsafe storage and access; including these behaviors in the model likely increase the estimated risks of infection. On the other hand, some households with IWS may employ point-of-use water treatment.
systems, which mitigate the risks posed by contamination if operated correctly and consistently over time. High-quality data sets of *E. coli* measurements in household storage facilities and household water treatment behavior in an IWS remain limited and make accounting for such variables in a risk framework difficult. It should be noted that this risk assessment does not include scenarios beyond daily consumption of drinking water. Therefore, the estimated risks of infection and subsequent burden of disease calculations do not include infection and disease from water quantity related behaviors such as food and hand washing or the use of water for household hygiene, which are likely modulated by the water scarcity associated with IWS.

Further uncertainty is introduced to the risk assessment by the population-specific dose–response functions for the reference pathogens used in the model. The dose–response data for each of the reference pathogens were collected in human feeding studies conducted in high-income settings with healthy, and generally, for rotavirus, male, adults. These dose–response functions may underestimate the risk of infection for persons living in LMICs, including children under five who suffer disproportionately from enteric disease, and attendant risks associated with nondiarrheal effects of exposure including the range of effects potentially associated with environmental enteric dysfunction (EED) and its potential downstream impacts. For each reference pathogen, the only disease end point considered was diarrhea, which neglects other, potentially more severe health outcomes such as stunting and chronic undernutrition related to EED. These dose–response functions also do not consider the risk of infection among people living in LMICs who may be more susceptible to infections due to compromised immune status or who, conversely, may benefit from acquired immunity due to endemic exposure. Additionally, dose–response models do not yet take into account the effects of coinfection, which is prevalent in LMIC settings and may lead to increased risks of infection and longer-term sequelae. The risks associated with unsafe water are codistributed in populations that are also at risk of undernutrition, high prevalence of coinfections, and other risk factors that would tend to exacerbate the effects of waterborne pathogen exposure. Risk estimates do not consider the elevated risks likely for infants, children, the undernourished, the immunocompromised, and those who are unlikely to receive timely treatment for diarrheal disease (e.g., oral rehydration therapy), which can dramatically reduce the risk of mortality among children in particular.

Besides the previously mentioned limitations in estimating the risks of infection, further sources of uncertainty in the burden of disease calculations include both the estimates of the IWS population and the diarrheal disease weighting metrics. In regard to the population exposed to IWS, the JMP piped-on-premise measures do not include those who receive water from standpipes served by distribution systems. Additionally, the IBNET database relies on self-reported data from utilities that are mostly located in urban areas. Taken together, our estimates using these assumptions likely underestimate the population exposed to IWS. For the diarrheal disease per-case burden, the use of rotavirus per-case DALY weighting for LMICs instead of that for high-income countries increases the overall burden of disease and means the rotavirus burden has an outsized effect on the overall burden estimates. For instance, in LMICs, the rotavirus DALY weighting is 0.482 per case with a case fatality rate of 0.6% in high-income countries, the recommended DALY weighting is only 0.0142 per case and the case fatality rate is 0.015%. We have presented the burden of disease based on the LMIC metrics, but we also provide alternative calculations with the high-income parameters in SI Table S12.

### Data Gaps

A recent review proposed a comprehensive research agenda relating to IWS. Our study further supports this agenda by identifying key data gaps for estimating the health risks attributable to IWS at the population level. First, there is a clear need for direct pathogen measurements from IWS networks in a range of settings, as water quality impacts may vary widely depending on local conditions. Such measurements could be used as direct input for a refined IWS risk assessment and could also be used to develop more robust pathogen to indicator ratios that can be applied to specific settings via a vis fecal indicator measurements. Additionally, for enumeration of fecal indicators, larger volumes of water should be assayed to lower the detection limit to levels more appropriate for risk assessment. Another research area concerns consumer behavior with regard to tap water consumption, household water management and treatment, and household water contamination. Our risk assessment utilized tap water consumption data from settings that are probably not representative of the complex water management behavior often observed among IWS users. A more accurate estimate of the health risks associated with IWS must include these household behaviors in the exposure assessment model. This study also underscores the need for dose–response models that are specific to LMIC settings where acquired immunity, coinfections, and host susceptibility could dramatically alter the infection probabilities associated with ingesting microbial pathogens. Lastly, there is a need for a more robust estimate of the global population served by IWS. The estimate used in this analysis was based on the projection of IBNET data onto the JMP estimates of the global population served by IWS. The estimate utilized in this analysis was based on the projection of IBNET data onto the JMP estimates of the global population served by piped-on-premise water supplies, and a simple dichotomy between “intermittent” and “continuous” without accounting for the degree of intermittency. It is likely that this underestimates the total number of people served by IWS.

### Policy Implications

Piped water supplies rely on multiple barriers including pipeline integrity, positive pressure, and chlorine residual to maintain the safety of the drinking water they deliver. These barriers, traditionally considered redundant, are more likely to fail simultaneously in the resource-constrained settings where IWS is prevalent. Our risk assessment indicates that the 925 million users of IWS are likely exposed to DALY burdens that exceed the WHO health threshold for each of the three reference pathogens considered. The predominance of risk due to the bacterial and viral pathogens in our estimate underscore the importance of an adequate chlorine residual in IWS distribution networks as a potential strategy to mitigate health impacts in the absence of massive investments to upgrade piped networks. Similarly, proper and consistent household water treatment and storage could mitigate the microbial risks of piped water supplies that are operated intermittently.

The Millennium Development Goal era has seen rapid expansion in coverage of piped water supplies, delivering a wide range of health and nonhealth benefits to communities. Increasing urbanization and population growth are likely to continue this trend. As more households connect to water supply networks, however, greater attention is needed on microbial risks associated with distribution systems, including those associated with intermittent function. Accounting for
these risks highlights the need for continued investment in provision of microbially and chemically safe water globally.

**ASSOCIATED CONTENT**

Supporting Information

The Supporting Information is available free of charge on the ACS Publications website at DOI: 10.1021/acs.est.7b01014.

Table S1: Summary of studies measuring fecal indicator bacteria in an IWS; Figure S1: Reported measures of central tendency and range for studies measuring fecal indicators in an IWS; Table S2: Summary of the epidemiological evidence concerning IWS and diarrheal disease; Figure S2: Boxplots of field observed and modeled E. coli counts; Figure S3: Frequency distributions of field observed and modeled E. coli counts; Figure S4: Cumulative distributions of field observed and modeled E. coli counts; Figure S5: Screening flowchart for IBNET utility records; Table S3: Point risk estimates using median E. coli counts; Table S4: Point risk estimates using mean E. coli counts; Table S5: Point risk estimates using GDWQ data; Figure S6: Cumulative distributions of daily probability of infection and burden of disease for Campylobacter; Figure S7: Cumulative distributions of daily probability of infection and burden of disease for Cryptosporidium; Figure S8: Cumulative distributions of daily probability of infection and burden of disease for rotavirus; Table S6: Sensitivity analysis results for Campylobacter; Table S7: Sensitivity analysis results for Cryptosporidium; Table S8: Sensitivity analysis results for rotavirus; Table S9: Initial IWS population estimate; Table S10: IWS population estimate by WHO region; Figure S9: IWS population map; Table S11: IWS burden of disease tabulations with LMIC rotavirus parameters; Figure S10: Cumulative distributions of annual diarrheal DALYs and deaths by etiology; Table S12: IWS burden of disease tabulations with HIC rotavirus parameters (PDF)

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Notes

The authors declare no competing financial interest.

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