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Laboratory Assessment of a Gravity-Fed Ultrafiltration Water Treatment Device Designed for Household Use in Low-Income Settings

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Abstract. Interventions to improve water quality, particularly when deployed at the household level, are an effective means of preventing endemic diarrheal disease, a leading cause of mortality and morbidity in the developing world. We assessed the microbiologic performance of a novel water treatment device designed for household use in low-income settings. The device employs a backwashable hollow fiber ultrafiltration cartridge and is designed to mechanically remove enteric pathogenic bacteria, viruses, and protozoan cysts from drinking water without water pressure or electric power. In laboratory testing through 20,000 L (~110% of design life) at moderate turbidity (15 nephelometric turbidity unit [NTU]), the device achieved log_10 reduction values of 6.9 for *Escherichia coli*, 4.7 for MS2 coliphage (proxy for enteric pathogenic viruses), and 3.6 for *Cryptosporidium* oocysts, thus exceeding levels established for microbiological water purifiers. With periodic cleaning and backwashing, the device produced treated water at an average rate of 143 mL/min (8.6 L/hour) (range 293 to 80 mL/min) over the course of the evaluation. If these results are validated in field trials, the deployment of the unit on a wide scale among vulnerable populations may make an important contribution to public health efforts to control intractable waterborne diseases.

INTRODUCTION

Unsafe drinking water is a leading cause of preventable disease, particularly among young children in developing countries. Waterborne pathogens, including a variety of viral, bacterial, and protozoan agents, account for much of the estimated 4 billion cases and 1.8 million deaths from endemic diarrheal disease each year. Among children < 5 years of age in developing countries, diarrheal disease accounts for 17% of all deaths. Microbiologically contaminated water also contributes to the heavy burden of disease associated with cholera, typhoid, paratyphoid, hepatitis, poliomyelitis, and gastroenteritis. Low-income populations are particularly at risk of such diseases because of the unavailability of safe water and sanitation.

Interventions to treat and maintain the microbiological quality of water at the household level are a promising alternative for households without access to a reliable supply of safe drinking water. In many settings, both rural and urban, household-based water treatment has been shown to be more effective in reducing endemic diarrhea than conventional treatment at the source or point of distribution. Among household-based water treatment interventions, filters have been shown to be particularly protective against diarrheal disease. Household-based water treatment has also been shown to be highly cost-effective.

Reaching vulnerable populations at scale with an effective, low-cost, long-lasting, and otherwise suitable water treatment device has been particularly challenging. Although promoters of chlorination, filtration, solar disinfection, and flocculation/disinfection reported increased coverage and uptake of household water treatment among low-income populations by 26% in 2006 and 2007 to 19 million people, this represents less than 2% of the persons without access to improved water supplies. It is even a smaller portion of those whose water is microbiologically safe. Although dozens of products have been developed and tested, few meet the microbiologic performance levels for reductions in bacteria, viruses, and protozoa established by the U.S. Environmental Protection Agency (USEPA) and incorporated into National Sanitation Foundation (NSF)/American National Standards Institute (ANSI) standards, and none of these has secured widespread coverage among low-income populations. Although some microfilters have been embraced over chemical disinfectants because of their capacity to improve water aesthetics, most such devices also present disadvantages, including comparatively high up-front cost, low output, limited longevity, and susceptibility to premature clogging and breakage.

Vestergaard Fransen S.A. (Lausanne, Switzerland), the main producer of pipe filters for the Guinea Worm Eradication Initiative and long-lasting insecticide-treated nets (LLINs) for malaria prevention, has developed a microbiological water purifier known as “LifeStraw Family.” The device is specifically designed to build on the company’s experience in rapidly scaling up the production and distribution of personal and household-based environmental health interventions among vulnerable, low-income populations. This work reports on laboratory testing of the microbiologic effectiveness, flow rate, and longevity of this new treatment unit.

THE WATER TREATMENT SYSTEM

The LifeStraw Family is a fully-integrated, gravity-fed, point-of-use microbial water treatment system intended for routine use in low-income settings. To meet the needs of the most vulnerable populations, it was designed to operate without electricity or other power and without a piped-in water supply. The unit was also designed to treat water of unknown microbiologic quality, and thus meet internationally recognized levels for microbiological water purifiers. It was also designed to operate under heavier levels of turbidity that may characterize water in such settings, especially during rainy seasons.

The microbiologic barrier consists of a 26-cm-long × 3-cm-diameter plastic cylindrical cartridge containing a number of hollow fibers with a 20-nm pore size. Although the cartridge is
METHODS AND MATERIALS

Setup and test waters. Test methods were based generally on EPA Protocol and Guide Standard for Testing Microbiological Water Purifiers (the “EPA Protocol”).

Aging was performed using water based on EPA general test water #1, except that the turbidity level was increased from 0.1 to 5.0 NTU prescribed by the Protocol to 15 nephelometric turbidity unit (NTU), and the organic carbon level was increased from 0.1–5.0 mg/L prescribed under the Protocol to 5 mg/L. These harsher conditions were intended to challenge the longevity and flow rate of the device. Microbial challenges were performed using water based on EPA challenge test water #3, except that the water was maintained at room temperature and not chilled to 4°C as prescribed by Protocol. The performance of occlusion devices, such as the LifeStraw Family, is not expected to be impacted by low temperatures, which are known to affect halogen disinfection. The parameters for the test water, including the materials used for adjusting the parameter, are set forth in Table 1.

Test organisms. The test organisms consisted of microbes shown to simulate the range of waterborne pathogens commonly found in untreated water. The bacteria group was represented by *Escherichia coli* (ATCC # 25922) spiked into the input water at concentrations of 10^7 to 10^10 colony forming units (CFU)/100 mL. The viral group was represented by male-specific coliphage MS2 (ATCC #15597-B-1) spiked into the input water at concentrations of 5 × 10^6 plaque forming units (PFU)/100 mL and inoculated into *E. coli* (ATCC # 15597) for assay. The MS2 coliphage has been recognized as a suitable surrogate for enteric viruses for water treatment processes\(^1\) and point-of-use device testing.\(^1\) The protozoan cyst group was represented by *Cryptosporidium parvum* oocysts spiked into the input water at concentrations of 5 × 10^4/L.

Microbiologic methods. *Escherichia coli* was grown overnight in Trypticase Soy broth (Difco, Detroit, MI) at 37°C to obtain the organisms in the stationary growth phase. The bacterial cells were pelleted by centrifugation and resuspended in phosphate buffered saline (PBS). This procedure was repeated three times to remove organic matter present in the broth. Bacterial assays were conducted by the membrane filtration method on m-Endo Agar LES (Becton Dickinson, Cockeysville, MD). Appropriate dilutions of influent samples were made in sterile 0.025 M PBS at pH 7.0. A 100 mL sample of undiluted unit effluent was also assayed. All assays were in triplicate according to Standard Methods.\(^1\) The MS-2 virus...
oocysts were obtained from the feces of infected calves and blub) for one hour to inactivate the oocysts to reduce risk during testing, the raw water reservoir was also cleaned with a seconds, and closing the backwash water tap. Once each week water tap to let the backwash water flow to waste during a few backwashing of the filter was performed whenever the flow of life (18,000 L). Thereafter, flow rates diminished to 60–110 L/minute. Over the 18,000 L design life, the mean flow rates ranged from 132 mL/minute to 159 mL/minute, with an overall mean of 146 mL/minute (8.8 L/hour). The average required interval for cleaning to restore flow rate was 11 hours of operation for the filter cartridge and 30 hours for the prefilter.

Filter life. In accordance with the terms of the study protocol, the device was tested through 20,000 L, representing 111% of its design life. Although flow rates showed some evidence of diminishing over filter life, all three units continued to produce at least 100 mL/min through the 18,000 L design life. There was no evidence of impaired microbiologic performance through 20,000 L of operation.

DISCUSSION

Results from this assessment indicate that the treatment unit is effective under controlled circumstances in removing a range of microbial indicators of fecal contamination for up to 20,000 L, or roughly 110% of its design capacity. The average log reductions exceeded 6 logs (99.9999%) of the test organism for bacteria, 4 (99.9%) of the test organism for virus, and 3 logs (99.9%) of the test organism for protozoan cysts.
These LRVs would meet the requirements for a microbial water purifier prescribed by the EPA Protocol.

The treatment unit continued to produce 100–130 mL of water/minute through 18,000 L, despite increasing the turbidity of the aging water to 15 NTU (150 times the minimum level prescribed by the EPA Protocol) and increasing the total organic carbon level to 5.0 mg/L (50 times the minimum). This is less than the 150 mL/minute design rate, but significantly greater than the flow rate from ceramic filters, which are also used in low-income settings. Cleaning was required, but at frequencies that probably would not exceed once per week under real world conditions.

In accordance with the study protocol, testing of the units was terminated after 20,000 L, representing 111% of design life. At this point, there was no evidence of any failure or diminution of microbiologic performance or flow rate. As the treatment unit has no residual disinfectant and a disinfectant also have been shown to meet the 6–4–3 standard, but requires batch treatment of a consumable product. Other common point-of-use water treatment products meet this international standard for bacteria, viruses, or cysts, but not all three.

Our results must be interpreted in the context of certain limitations. First, this assessment was undertaken under controlled laboratory conditions, not in the field and not as the unit may actually be used by householders. Second, this evaluation was undertaken using a single aging and challenge water. Although these waters were specifically designed to reflect the key parameters that would challenge filtration devices (and actually exceeded the EPA guidelines for turbidity and TOC), the performance and life of water treatment units can be affected by various chemical and physical conditions that may not be encompassed by these tests. Finally, the 20,000 L evaluation reported here was conducted over just 10 months, less than a quarter of the time a householder might actually be expected to use the device in the field. It is possible that use of the device over longer periods in the tropics could accelerate the growth of biofilm on the hollow fiber membranes and thus impair flow rate or cause premature choking. The manufacturer reports that it has developed a slow-eluting chlorine donor that can be permanently deployed in the unit under the prefilter if field testing shows evidence of adverse impacts because of biofilm. However, this chlorine donor was not incorporated into the units we tested.

We note that as the treatment unit has no residual disinfection, the treated water is immediately susceptible to recontamination, a particular problem in the low-income settings for which it was designed. Although the manufacturer has designed an alternative configuration that includes a collapsible or rigid container to improve the safe storage of treated water, this will add to the cost. Field testing is underway to investigate the extent to which such recontamination actually occurs when the devices are used by a target population.

Notwithstanding these limitations, this study does establish the basis for further testing in the field. Such testing is necessary to confirm the durability of the system and to identify any potential gaps in performance under actual field conditions.

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**Table 2**

Summary of log reduction values (LRVs) at each sampling point

<table>
<thead>
<tr>
<th>Test point</th>
<th>Percentage of design life of unit</th>
<th>Volume passed (L)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>Unit 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Escherichia coli</em></td>
<td>&gt; 7.1*</td>
<td>&gt; 8.3</td>
</tr>
<tr>
<td><em>MS2</em></td>
<td>3.8</td>
<td>5.7</td>
</tr>
<tr>
<td><em>Cryptosporidium oocysts</em></td>
<td>&gt; 3.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Unit 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>E. coli</em></td>
<td>6.6</td>
<td>6.3</td>
</tr>
<tr>
<td><em>MS2</em></td>
<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td><em>Cryptosporidium oocysts</em></td>
<td>&gt; 3.1</td>
<td>&gt; 3.6</td>
</tr>
<tr>
<td>Unit 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>E. coli</em></td>
<td>&gt; 7.1</td>
<td>6.8</td>
</tr>
<tr>
<td><em>MS2</em></td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td><em>Cryptosporidium oocysts</em></td>
<td>&gt; 3.1</td>
<td>&gt; 3.6</td>
</tr>
</tbody>
</table>

*Log* reduction. Figures in italics are individual sampling points where the LRV was below the 6–4–3 average for bacteria, viruses, and cysts, respectively, under the EPA Guide Standard.

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**Figure 2.** Flow rate (mL/minute) of tested units over 20,000 L.
It is also important to assess the performance and life of the treatment unit under a wider variety of water conditions and when subjected to less than optimal maintenance. The ultimate objective of water treatment units such as this, however, is not only to improve water quality but to improve human health. The increasing body of evidence suggesting the potential for household water treatment to dramatically reduce diarrheal morbidity provides good reason to believe that the device can also prevent disease. If this turns out to be the case, then a company that has demonstrated success in the widespread distribution of environmental health products to low-income populations should be encouraged to scale up the intervention on an affordable and sustainable basis.

REFERENCES
