

Household water treatment and storage may play a role at each of these stages. In an emergency context, when normal supplies of drinking water are interrupted or compromised, affected populations have long been encouraged to boil or chlorinate their drinking water in order to ensure its microbiological integrity (CDC, 1993). More recently, the treatment of water at the household level has been shown to be more effective in preventing even endemic diarrhoea than traditional methods of improving or protecting the microbial quality of water at the source or to the point of distribution (Clasen, 2005; Fewtrell, 2005).

With the assistance of the WHO, and funding from Hindustan Lever Ltd., we undertook this study to investigate and document the drinking water response in the immediate aftermath of the tsunami, including the role of household-based water treatment and safe storage. This paper presents and discusses the main results of that investigation. It also makes recommendations for the future based on our findings.

METHODS

Shortly after the tsunami, we began monitoring broadcast, web and print media to obtain information relevant to the drinking water response and to identify organizations that were involved therein. Commencing four weeks after the event, we started contacting the identified organizations, including governmental ministries and authorities, UN agencies, NGOs and private-sector companies. We explained that we were working with the WHO to investigate and document the drinking water response, including the role of household-based water treatment interventions. We encouraged them to provide any relevant information, including copies of any reports or accounts that addressed drinking water issues, and to supply us with the names and contact details of their representatives in the field. We contacted these representatives by phone and email and asked them to provide any further relevant information and reports.

Commencing approximately eight weeks following the event, we began two-week field assessments in India, Sri Lanka and Indonesia. These countries were selected because they collectively represent a significant majority of the human casualties (known dead or missing) and perhaps a similar portion of internally displaced persons (IDP) living in camps or temporary shelters. We interviewed national, regional and local representatives of organizations involved in addressing drinking water issues, obtained copies of reports, and accompanied them on visits to affected areas. During our field work, we interviewed on-site relief personnel working on water, sanitation and hygiene projects, including local personnel involved in providing water. We also met with health workers, mainly in temporary clinics. Finally, we interviewed victims of the disaster and solicited their input on the drinking water response from the immediate aftermath through the first four months. A list of the organizations that provided information for this study appears in Annex 1.

Although we took steps to collect as much relevant information as possible, circumstances limited our investigation. First, while we intentionally delayed our investigation so as to minimize interference with the response itself, the continued priorities of attending to the emergency at times limited our access to key personnel. Second, logistical issues and costs

permitted us to conduct field assessments in only selected countries and locations. Third, in soliciting information for this study, we agreed to respect the confidentiality of our sources, where necessary, in order to encourage candid disclosure, respect privacy and protect proprietary information. While we acknowledge that these factors may bias our results, they are the limitations that typically attend emergencies of this kind and thus may be necessary to some extent in order to obtain potentially useful lessons.