

Ear Acupuncture and Humanitarian Aid:

History, application, and improvement of the NADA model

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Abstract

The NADA model is a training and therapy approach involving a standardized ear (auricular) acupuncture protocol used for various health conditions. This paper contends that as a capacity-building tool, the NADA model is an appropriate humanitarian aid intervention in the aftermath of disaster/war. The model has historical roots in the barefoot doctor movement, Chinese medicine, and French physician Paul Nogier's auricular medicine system. The protocol was developed in New York at Lincoln Hospital as an addictions therapy, and has since been integrated into a variety of humanitarian aid contexts. As a model, the protocol is taught to lay health workers and local personnel, provided as a barrier-free component of recovery services, and offered in a group setting on a regular basis for people seeking assistance. Due to the versatility of applications, the model can be integrated within a variety of behavioral health and humanitarian aid settings. This paper also discusses how the US non-profit organization NADA (National Acupuncture Detoxification Association), NADA trainers, and full body acupuncturists can work to improve the use of this model in the aftermath of disaster/war.

Introduction

The National Acupuncture Detoxification Association (NADA) ear acupuncture protocol, originally developed in the 1970's for addictions treatment, has since been applied more broadly and is used within a wide variety of community health settings. Consisting of five points in the outer ear, these points are understood to have a balancing effect on the body. The protocol was pioneered at Lincoln Hospital in the Bronx, NY. Lincoln specialists created an entire model of training around the philosophy of the protocol, in terms of approach, application and execution. This approach is known as the NADA model. The protocol is taught to local community workers and lay health personnel who can provide ongoing cost-effective services. Practitioners offer it as a non-verbal therapy, applied in a group setting and integrated as a component of self-help and comprehensive behavioral health care. Training and advocacy for the NADA model is carried out by the not-for-profit US organization, the National Acupuncture Detoxification Association, as well as international NADA groups.

Since the 1990's, the NADA model has been integrated as a component of humanitarian relief efforts following natural disasters and war, postwar, and refugee contexts. Examples of international aid programs that have helped facilitate these efforts include Catholic Relief Services, USAID, Partners in

Health and Real Medicine. Trainers of the NADA protocol teach local personnel how to apply the technique within their community. This paper contends that as a capacity-building model—not a medical missions brigade—the NADA model is designed to reinforce local capacities. As such, it can be an appropriate intervention for humanitarian aid, as part of short-, medium- as well as long-term recovery efforts.

Because conducting standardized controlled research within a post-disaster/war environment is inappropriate, the evidence base for this humanitarian aid modality is limited. Nevertheless, qualitative data collected with standardized self-report assessments, anecdotal data narrative reports, and client-usage from within many programs that use the NADA protocol demonstrate its value within these contexts. Recent pilot reports on the outcomes of NADA trainings in humanitarian aid contexts show promise that locally-trained health workers are able to apply the protocol effectively as a community health tool (Cole & Yarberr, 2011, Yarberr, 2010, Naku, 2010).

Evidence exists to support the use of the NADA protocol within a variety of health settings, including addictions, psychiatric, prisons, harm reduction and cancer therapy (Valois et al., 2012, Carter et al., 2011, Chang, Sommers & Hertz, 2010, Harding, Haris & Chadwich, 2008, Payer et al., 2007, Santasiero & Neussle 2007, Stuyt & Meeker, 2006, Janssen, Demores & Whynot, 2005,

Berman et al., 2004, Nixon, Cheng & Cloutier, 2003, Berman & Lundberg, 2002, Russell, Sharp & Gilbertson 2000, Avants et al., 2000, Shwartz, Saitz, Mulvey and Brannigan 1999). The acceptability of acupuncture as a behavioral health therapy is also well established. The US federal government's Center for Substance Abuse Treatment (2006), the United Nations (2006), as well as the US Department of Defense/Veteran's Affairs (2010) have each published guidelines that address the value of acupuncture for conditions such as chemical dependency and post traumatic stress disorder (PTSD).

The problems of humanitarian aid projects are well documented (Wolfberg, 2006, Van Tilburg, 1995, Roberts, 1995, Bezrucha, 2000). Challenges exist for both outside aid groups and the local communities affected. Though altruism and good intentions may guide the efforts, bringing aid into a sensitive region does not come without its hazards and possible harm for those assisted as well as the aid workers themselves. Aid workers may possess knowledge of local traditions, languages, and cultural nuances/norms/mores, yet still not provide care with cultural competency. Long-term assistance from outside humanitarian aid groups can create a dependency and paternalistic relationship between aid workers and vulnerable, devastated communities. It can disrupt local traditions and health systems and put local doctors out of

work. Medical aid, as is promoted by the western psychiatric model, also has limitations and hazards. Diagnosing entire populations with post-traumatic stress disorder (PTSD), for example, may actually be inappropriate in places affected by war (Summerfield, 1999). The labeling and application of Diagnostic and Statistical Manual (DSM) diagnoses onto populations by international aid groups can contribute to victimizing and neocolonial transference (Shah, 2007).

Notwithstanding, in the aftermath of disaster or war, access to health care may be limited and outside aid may indeed be necessary. What is, then, the appropriate role of humanitarian aid? Summerfield (1999) suggests, “Perhaps the primary task of interventions is to identify patterns of social strength and weakness and reinforce local capacities. This will rightly favour agencies interested in more than ‘hit and run’ operations” (p 1461).

The NADA model offers one appropriate humanitarian aid intervention for community empowerment. This paper explores the history of this modality, beginning with the barefoot doctor movement in China, the NADA protocol’s origin in New York, and its expansion as a disaster relief tool worldwide. Second, the paper outlines the components of the NADA model, and describes its applications as a behavioral health tool as well as a humanitarian aid intervention. Finally, suggestions are offered for improvement of

acupuncture-based humanitarian efforts, including the role of NADA as an organization, and how full body acupuncturists can assist.

History

Origins of ear acupuncture and the barefoot model

Acupuncture is a therapy within the field of Oriental medicine, also referred to as Traditional Chinese Medicine or East Asian Medicine. Ear acupuncture—known also as auriculotherapy and auricular acupuncture—is the use of diagnostic methods and therapy points applied exclusively to the outer ear. The origins of ear acupuncture methods are not necessarily Oriental or Asian. Rudimentary forms of ear puncturing and cauterization were practiced in the Middle East and Northern Africa, even by Hippocrates, the father of Greek medicine. The first system of ear acupuncture was developed by the French physician Paul Nogier in 1956 (Gori & Firenzuoli, 2007).

Nogier's auricular system was adapted and researched by the Chinese military in the 50's (Gori & Firenzuoli, 2007). Amidst health care reform in China during the Cultural Revolution, acupuncture training programs, particularly abbreviated protocol-based education, played an important role in making acupuncture accessible to rural and impoverished communities. The model

developed by the Chinese government, known as the *barefoot doctor* model, taught over a million community workers, known as health promoters, in basic acupuncture protocols and other medical prevention/intervention methods. These health promoters were able to provide simple acupuncture treatments in rural areas and to populations who had no access to other health care (Valentine, 2005).

In the 1970's, the World Health Organization explored the potential for China's barefoot doctor program as a community health model (Valentine, 2005). Barefoot doctor acupuncture training programs, modeled after China's, were implemented in the Philippines (Torres & Berza, 2010) as well as the USSR (Birch & Felt, 1999). One program was implemented in Mexico, which came to be known as *Medicina Popular* or "folk medicine." This model took root within Christian groups, which promoted the use of methods including ear acupuncture as a component of self-help care (Napolitano, 2002).

The barefoot doctor program in China was found to cut costs for the Chinese health system. Many of today's acupuncturists in China and the US were in fact originally trained as barefoot doctors (Zhang & Unshuld, 2008). Though the barefoot doctor program was discontinued, protocol-based acupuncture training programs continued within China. Today, the Chinese military's training program for medical personnel, as well as common soldiers, provides

instruction in basic acupuncture techniques. This program has been noted as a key component of modern-day military medicine (Guan, 2011).

Origins and development of NADA

In the 1970's, Dr. Michael Smith, along with other physicians and community activists at Lincoln Hospital, created an ear acupuncture protocol based on research in China. They chose five points based on Nogier's ear point system. The treatment was first implemented as a heroin and methadone detoxification treatment, and later piloted within Lincoln's program as a component of ongoing outpatient and inpatient addictions and psychiatric treatment (Smith, 2010).

NADA is considered the barefoot doctor movement of the United States (Mitchell, 1995). Lincoln Hospital established a training program so community workers worldwide could come to the hospital, learn the technique, receive clinical experience providing the therapy, and return to establish their own clinics. By 1985, a non-profit organization, the National Acupuncture Detoxification Association (NADA), was established to maintain standards of training and provide education and support for communities seeking to bring ear acupuncture into public health settings. In the 1980's, NADA trainers assisted medical programs in Hungary (Birch & Felt, 1999) and Nepal (J&M Reports, 1997) to establish their own local groups. NADA

estimates that over 25,000 providers worldwide have been trained in over 40 countries (NADA, 2013).

Expansion of NADA as a disaster relief tool

The first example of the NADA protocol used in the field of disaster relief to treat symptoms of trauma can be traced to the early 1990's. Community workers and trainers taught refugee health promoters how to apply the NADA protocol for affected groups within post-civil war Guatemala (NADA, 2008).

The NADA protocol has since been provided in a variety of post-terrorism and war contexts, notably after September, 2001 in New York City, where St.

Vincent's Hospital offered the NADA protocol for survivors, firefighters and other first responders (J&M Reports, 2001a, 2001b). In the years of recovery after, St. Vincent's and branch sites continued to offer the NADA protocol for people affected by the events of September 11 (J&M Reports, 2003a, 2003b, 2004, 2005, Dolan & Menolascino, 2010).

On the Thai/Burmese border, capacity-building programs for refugee workers in the NADA protocol took root in the aftermath of a humanitarian crisis (J&M Reports, 2001, 2002). Since, the NADA protocol has become a part of refugee health care (DARE Network Staff, 2011). As a response to war and in areas of conflict, the NADA protocol has been applied specifically to address

the effects of violence in Uganda (Yarberry, 2010), the Gaza Strip (Schnabel, 2011), Lebanon (Bernal, 2011) and Mexico (Kocherga, 2012).

NADA protocol-based relief services have also been established in the aftermath of natural disasters, first documented during tornado relief efforts in South Dakota (Voyles, 2001). Following Hurricane Mitch in 2002, Honduran providers were taught the NADA protocol and were able to provide services for their communities long after humanitarian aid workers left the area (J&M Reports, 2002). NADA-trained providers have worked closely with relief agencies to offer NADA protocol treatments as part of disaster relief services following Hurricane Katrina in New Orleans (NADA, 2005a, 2005b, Toomin & Williams, 2005), the oil spills of the Gulf Coast in 2010, (Bursac, 2010), and most recently following the devastation from tornadoes in Joplin, Missouri (Bursac, 2011, Sommers & Porter, 2011), Minnesota and Massachusetts (Sommers & Porter, 2011).

International relief efforts used the NADA protocol to treat people within earthquake-devastated Pakistan (O'Regan, 2006, NADA, 2006) and Chile (Georgieff, 2010), and in the aftermath of tropical storms in the Philippines (NADA, 2009). Following the 2010 earthquake in Haiti, relief efforts included NADA protocol treatments in the immediate aftermath, as well as ongoing

trainings for Haitian health promoters. Today, NADA protocol treatments are provide by Haitian workers on a regular basis, under the aegis of local health organizations (Raneri, 2010, Cole, 2010, Cole & Yarberrry, 2011, Johnson, 2010, Fried, 2011).

The NADA model

As the NADA protocol was pioneered, Lincoln Hospital created a model of support for community health programs, known as the NADA model. The model established the protocol not as a panacea for the masses, nor as a stand-alone therapy, but rather most effective as an adjunct to comprehensive care (NADA, 2010, Smith, 2010). (See figure 1, page _____). This section describes these components as well as the applications of the NADA model in various settings.

Figure 1: Components of the NADA model

Integration within other interventions: These may include a supportive non-confrontational approach to counseling and medical care; an emphasis on self help, peer mentoring and/or 12 step groups early in the recovery process.

Barrier free: NADA treatments are offered as a "barrier free" treatment; lengthy assessments and intake are unnecessary to screen for "appropriate" patients. The NADA clinic serves as a "front end" to the other services, allowing the client the opportunity to experience "something significant" prior to committing to a treatment or medical plan.

Regular treatments: Treatment is available without appointment throughout the week, ideally on a daily basis in early stages of treatment.

Communal setting: NADA treatment is provided in a group setting for a duration of 40-45 minutes. All clinical activities take place within a tolerant informal family-like atmosphere.

Local personnel and/or cross-trained health providers offer the therapy: Service delivery of the NADA protocol should not be dependent on full body acupuncturists or physicians. To maximize the cost-effectiveness, the accessibility of the treatments, and cultural competency, NADA protocol treatments are provided by NADA-trained health workers who already work within the existing community health program.

Use of toxicologies to monitor progress: when in the context of addictions treatment or pharmaceutical medication detoxification/tapering, frequent toxicologies are emphasized to monitor progress.

Collaboration with court-agencies: Clinicians have a willingness to work with court-related agencies, including drug court, mental health court and veteran's court.

Components

There are several components of the NADA model that make it an effective system of care. The first component is integration with other interventions. It was designed to treat heroin and methadone addicts, wherein the person seeking recovery could receive the ear protocol treatments while at the same time attend 12-step based self-help and other therapy groups. Lincoln emphasized faith-based social rehabilitation. The addict would receive education in not only the emotional and spiritual causes of chemical dependency, but also the social, political and economic context that shapes the problem of addiction. Today, programs that utilize the NADA protocol may offer a variety of other community health interventions such as group therapy, individual counseling, case management, art therapy, yoga, other self-help groups, herbal medicine, medical and pharmacological care.

The second component of the NADA model is the barrier-free setting. Lincoln physicians found that the NADA protocol could be applied without diagnosis, making lengthy assessments and intake unnecessary for screening patients. At the core of this approach to recovery is a barrier-free, “no nonsense” method of care. As such, anyone could receive treatment at Lincoln, regardless of ability to pay. Patients who were in early “pre-contemplative” stages of recovery could also receive treatment. For people on waiting lists to enter a treatment program, the NADA protocol can be administered during their weeks or months of awaiting admission. This type of care can therefore occur after or before an Alcoholics Anonymous group,

in a community center or a church, a syringe exchange program, or in the waiting room of a psychiatric hospital: any place where people can sit. In many settings the NADA protocol is offered as a “front end” to other clinical services. Many programs offer the NADA protocol for patients prior to lengthy intake assessments. This allows patients to receive something significant prior to committing to a treatment plan. The treatment is also provided as a component of recovery maintenance and relapse prevention.

A third component of the NADA model is the importance of regular treatments. Rather than offering a “magic bullet” or “quick fix” for complex problems like addictions, mental illness and trauma, the NADA protocol is one part of a process of recovery. Ideally, the treatments are readily available and accessible for people as needed, regardless of ability to pay. This approach is similar to 12-step or other self-help groups, where early in the recovery stages, regular sessions are recommended.

A fourth component of the NADA model is the communal setting. The NADA model emphasizes that all clinical activities, including counseling, self-help care, and NADA protocol treatments, should be provided within a tolerant, family-like and communal atmosphere. Lincoln first offered NADA protocol treatments in a group setting because the demand was so high. Group-based treatments proved to be the most cost- and time- effective way to provide care for the community. Keeping the

costs down made the treatment much more accessible to people with low incomes, and allowed treatment programming to survive budget cuts. The group setting has other advantages as well. It reinforces the social and communal aspect of healing and creates a safe space for people who are intimidated or do not feel safe in individual, private settings.

A fifth component of the NADA model assumes that local personnel, not necessarily outside workers, are the ones providing treatment. As such, the entire NADA model can be taught, implemented and sustained under the aegis of local community structures. The NADA model is designed to empower communities with a cost-effective and safe tool, offered as a non-verbal alternative to drug-based and talk based therapy. With local personnel trained, the program has optimal capacity for cultural competency and sustainability, and they are not dependent on outsiders to do the work for them. Those with advanced training and sufficient experience providing the NADA protocol may be eligible to undergo apprenticeship to become a NADA trainer.

A sixth component assumes that lay workers, not necessarily highly trained physicians or licensed acupuncturists, can provide the therapy. The protocol may be applied effectively without diagnosis. This allows the NADA protocol to be utilized within non-medical, non-professional, and faith-based settings. Because higher-trained physicians and acupuncturists cost much extra for a

program to hire, having lay workers providing therapy maximizes the cost-effectiveness of services. Many 12-step oriented groups offer the NADA protocol as an adjunct to self-help recovery. Native American reservations and refugee camps have offered the NADA protocol, with treatments provided by non-professionalized lay workers. Pastoral care workers within churches, temples, mosques and monasteries have also offered NADA protocol treatments. These settings—places that local communities know, trust and where they routinely gather—can provide a safe, supportive and respectful environment for everyone seeking assistance.

Applications within behavioral health

The NADA model adapts well to different settings and populations. In prisons, for example, inmates receive the ear acupuncture as a routine stress relief activity to reduce aggression. In psychiatric hospitals, nurses offer NADA ear acupuncture as an alternative or adjunct to the drugs they administer. For behavioral health and trauma practitioners, the NADA protocol offers an alternative non-verbal psychosocial intervention, a unique intervention in the behavioral health field where “talk-heavy” counseling methods are emphasized. Other types of health workers have also used the NADA protocol for various conditions. For example, peer counselors within sickle cell support groups offer the protocol to alleviate and prevent sickle pain crises.

Applications as a humanitarian aid intervention

The NADA model is ideal for international and cross-cultural settings. As a non-verbal therapy, the practitioner does not need to speak the language of the person receiving the treatment. The role of the NADA model within humanitarian aid interventions will depend on the particular needs and stage of recovery that the community is facing. In the immediate aftermath of a disaster, either local or outside aid groups may provide the therapy. In these short-term situations, the NADA protocol may be offered as a stress relief service, offering a safe, communal, and non-specific therapy for displaced people as well as for first responders. It can also be of assistance to people experiencing a specific psychiatric symptom.

Figure 2

Challenges with Outside Aid Projects	Specific Problems presented	Strengths of the NADA Model
Cultural competency	<ul style="list-style-type: none"> •Language barriers •Outsiders doing the work •Local systems, customs aren't respected 	<ul style="list-style-type: none"> •NADA is non verbal • Can be performed by local personnel •Designed to function within local systems
Sustainability	Dependency on outside aid Contracting outside aid specialists is expensive	<ul style="list-style-type: none"> •Needles are inexpensive • Lay personnel can learn and apply safely and effectively •Designed to empower local communities
Appropriate use of the Western Psych Model	<ul style="list-style-type: none"> • Potential inappropriateness of DSM Diagnosis • Drug therapy and talk therapy not always appropriate 	<ul style="list-style-type: none"> •NADA requires no diagnosis • Ear acu is not a drug • Designed to function as a brokering and complementary role within the western model

Medium-term support entails training local personnel so they are better equipped to respond to mental health, addiction and other health problems. Long-term support requires implementing measures to ensure that local groups have autonomy in the capacity to provide ongoing services and training. This may require NADA trainers to provide apprenticeship for local personnel and teach them how to conduct their own trainings. In this stage, as well, local groups, with the support of NADA trainers, may develop their own regulatory systems and rules to oversee the practice of the NADA protocol. In addition, long-term support may require public policy reform to

allow local and lay personnel to provide the NADA protocol as part of their scope of practice.

Because the NADA protocol can be effectively and safely taught to local health providers, many avenues exist for its expansion within relief efforts. Nurses within large-scale health institutions as well as volunteer health promoters in mobile settings can both be trained and equipped to offer the NADA protocol. Fire departments, government agencies and hospitals have used the NADA protocol to treat the short, medium and long-term effects of trauma. NADA protocol services have fit in alongside disaster relief services of the Red Cross, Catholic Charities, the International Firefighters Association, and the Medical Reserve Corp.

Settings like shelters and community centers, open to the public, can offer an ideal, barrier-free environment for anyone seeking care. Volunteers from the community can assist in setting up a NADA group in such places. In some settings, NADA protocol groups can be a gateway for people needing additional psychiatric support and referral. NADA providers are trained to refer such individuals to appropriate levels of psychiatric or addictions care.

With local and lay providers equipped to provide therapies, the NADA protocol can conveniently be integrated into existing health care systems.

Working “within” the community, NADA providers are able to assist a broad-spectrum of persons affected by violence and trauma, which may include: victims, families of the deceased or disappeared, police, soldiers, and even perpetrators of violence. Programs can be set up so that everyone can receive treatment together in the same setting. If desired, programs can also be set up so that, for example, survivors of domestic violence can receive treatment within their own self-help group. In such settings, a NADA protocol group serves as a supportive, safe, and quiet space for anyone in need; a nonviolent and neutral refuge for everyone.

One example of a sustainable NADA protocol-based humanitarian effort was a Kenyan refugee program sponsored by Real Medicine. The refugee community was in transit and displaced, and people were living in an unstable, war-torn environment. However, the project was sustainable because providers were trained from within the refugee population. The 21 refugee workers provided 18,000 NADA protocol treatments within a 6-month period (Yarberry, 2010).

Improving acupuncture based humanitarian efforts

Relief efforts involving acupuncture or the NADA protocol are not immune to problems observed in past humanitarian medical aid efforts. Without careful

and community-based implementation of a NADA-based disaster relief program, it can come across as culturally insensitive, can contribute to dependency and may be misused as an inappropriate psychiatric intervention.

For current and future acupuncture-based relief efforts, programs that use the NADA model can help improve the quality of care for devastated populations. Once local health providers are equipped with NADA training, communities are empowered to provide more cost effective, ongoing, sustained NADA group sessions for trauma survivors, as part of emergency response teams, and for the general public.

The role of NADA as an organization

In the field, the role of NADA, a US-based non-profit, is to work with community health providers and advocates to establish NADA protocol services within public health settings, particularly for underserved groups. Today an estimated 2000 addictions treatment, harm reduction, correctional drug court and mental health programs worldwide use the NADA protocol as adjunct therapy. Members within the organization NADA include hundreds of therapists, acupuncturists, medical doctors, nurses, first responders and lay-workers, actively networking in order to help raise consciousness about the benefits, the uses, and the limitations of the treatment.

NADA has assisted disaster relief groups in various capacities, including fundraising and public education. NADA helps agencies to locate experienced

NADA trainers and local practitioners qualified to provide relief services, training, and consultation for long-term planning. In past disaster-relief efforts, NADA trainers have helped facilitate coordination with the Red Cross, local hospitals, local firefighters and other national and international relief agencies. Annual NADA conferences in the US and Europe feature presentations from disaster relief and trauma specialists.

NADA is also actively involved in policy-making advocacy to ensure that local regulations permit NADA trainees to treat trauma and mental health conditions, and so that interstate reciprocity would allow outside NADA trained volunteers to assist during times of disaster. For example, in the aftermath of Hurricane Katrina, NADA trainers worked with the state firefighters' lobbyist to install a NADA policy in Louisiana. This policy included a reciprocity clause which enabled all NADA trainees as well as all licensed acupuncturists, to have inter-state mobility to assist in the Gulf region in times of crisis (Renaud, 2007). This reciprocity inclusion allows acupuncturists and NADA registered trainers, working with disaster relief groups like Community Relief and Rebuilding through Education & Wellness and Acupuncturists Without Borders, to assist Louisiana communities in establishing NADA clinics as a trauma therapy. Years later, as a result of this NADA policy, NADA-based disaster relief clinics following the 2010 oil spill

were easily and cost-effectively established by local NADA trainees (Bursac, 2010).

How full body acupuncturists can help

With these past efforts, several acupuncture-based humanitarian and international health development groups have emerged over the past few decades, including the Guatemalan Acupuncture and Medical Aid Project (Ibarra et al., 2004), the Pan African and Medical Aid Project (Mandell, 2011), the Beirut Acupuncture Project (Bernal, 2011), the Crossroads Border Project (2013) Acupuncture Ambassadors (2012), Acupuncture Relief Project (NADA, 2010) and Acupuncturists Without Borders (Fried, 2010). Within these groups, the NADA protocol is a common technique used for training and as therapy for a wide variety of health conditions and symptoms, as well as for general stress relief, relaxation, community support and wellness.

As these groups have demonstrated, acupuncturists arriving in the aftermath of a disaster can play a role in a community's recovery by facilitating immediate support and offering opportunities for capacity building and NADA training for local health personnel. Such acupuncturists interested in the field of disaster relief will benefit by receiving NADA training, so they can learn how to implement the NADA model. For groups like Acupuncturists Without Borders, in recent years, training local health workers in the NADA protocol

has been a new approach to disaster relief. By using the NADA model, and combining this with the charitable efforts of outside volunteers, groups can build trust and facilitate sustainable long-term recovery efforts.

Conclusion

Neither acupuncture, nor the NADA protocol, nor any single modality can provide sufficient help for populations affected by disaster, war, and widespread poverty. These situations pose unique challenges for all groups, including governmental, local agencies and outside aid programs. Humanitarian aid interventions must always be carried out in a careful, thoughtful and community-based manner, geared towards not only providing immediate assistance, but also working with local communities towards sustainable solutions. It is with this sensitive and grassroots spirit that the NADA model emerged in the 1970's heroin epidemic in the impoverished South Bronx, NY - a situation that required a culturally competent, drug-free, comprehensive, and sustainable approach which would address the root causes of addiction.

This model has since been implemented and its successes documented in numerous international relief efforts since the 1990s, and will continue to expand in the future. In response to disaster and war, the NADA model has demonstrated to be an appropriate humanitarian aid intervention for short-, medium-, and long-term recovery efforts. The versatility of the model makes it unique among other modalities, allowing it to fit in practically and cost-effectively with other community programs, whether their foci are physical, mental, or emotional health.

As a non-verbal and communal healing process, and requiring no diagnosis in order to qualify for treatment, the NADA protocol is well suited for an array of environments, settings, and populations, and able to be provided by local, lay personnel. The entire NADA model, not just the specific ear acupuncture protocol, can be taught to local communities.

The US non-profit organization NADA is established and well-positioned to support individuals and agencies wishing to start a NADA model program. All health workers and groups involved in humanitarian aid at any level can benefit by learning about how the NADA model fits into their existing and future health work, as well as how to support other projects using this model. As the need for innovative, cost-effective, sustainable approaches in the field of humanitarian aid continues to grow, the future for this work lies in collaboration and complementary efforts. The NADA model can be part of this solution.

About the author

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