Impact and evolution of health care delivery following the mass influx across the Ceuta border: analysis of the first seven days

Impacto y evolución asistencial tras la entrada masiva de personas por la frontera de Ceuta: análisis de los primeros siete días

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The Autonomous City of Ceuta is a border enclave presenting particularly complex healthcare challenges because of its small geographical area, its location in North Africa, and the existence of a direct land border between Spain and Morocco. Its healthcare system, managed by the *Instituto Nacional de Gestión Sanitaria* (INGESA), includes a 061 Emergency Medical Service comprising 1 out-of-hospital emergency unit and 1 primary care urgent care service (SUAP), 3 primary care centers, and 1 referral hospital with 252 beds, 6 operating rooms, 14 intensive care unit (ICU) beds, and 8 emergency department observation beds.[1] This healthcare capacity came under exceptional pressure on July 30, 2026, following the unauthorized entry of approximately 72,000 people through one of the city's border crossings.[2] The objective of this study was to describe the healthcare response during the first seven days and analyze the main opportunities for improvement in preparation for future mass arrivals.

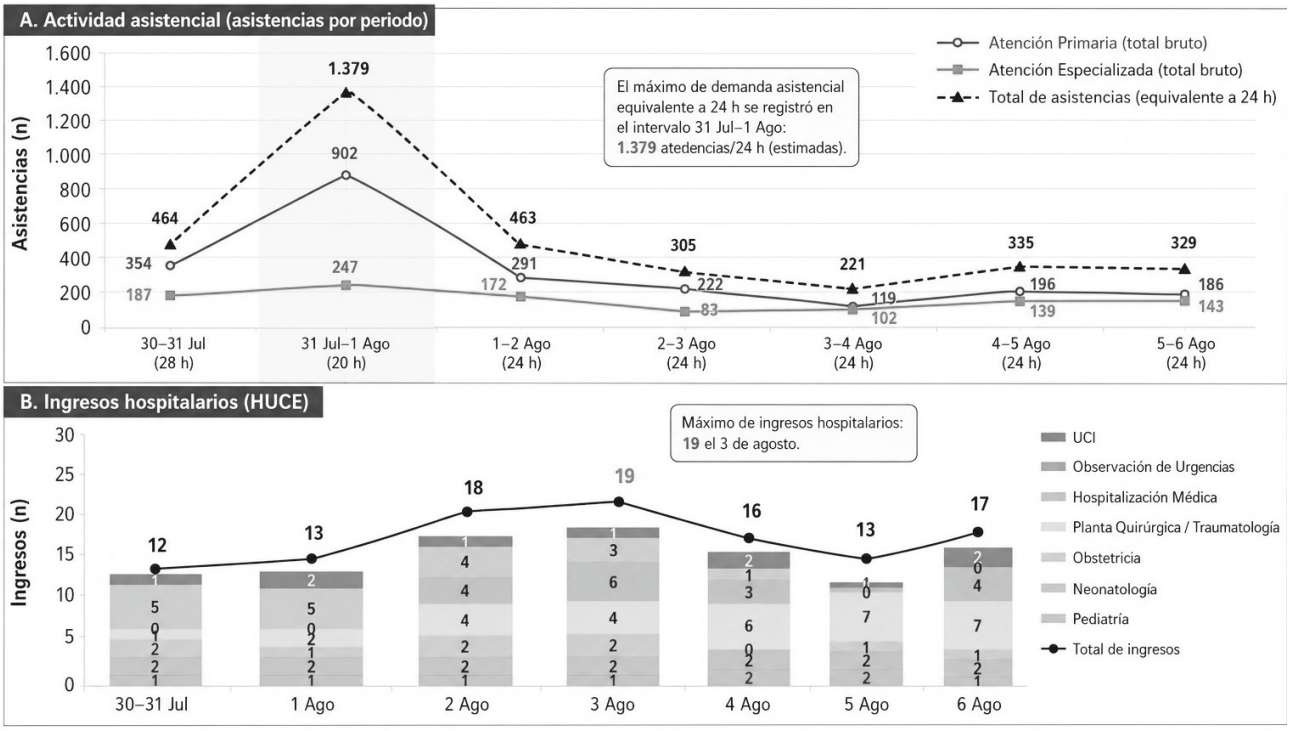
We conducted a descriptive analysis of the health care services provided to migrants treated by Ceuta's healthcare facilities during the first week of the incident. Operational records and data reported by INGESA and healthcare facilities were reviewed, together with available information on the organization of the extraordinary response. As background, the External Disaster Response Plan had been developed and revised following the arrival of approximately 8,000 people in May 2021.[3] During the first 4 days, owing to the high demand for health care and language barriers, prehospital activity was recorded only as numerical data. Complete clinical records were obtained only when hospital care was required. Even in these cases, patient identification data were of limited reliability because fictitious names were commonly used out of fear of subsequent identification for deportation purposes.

Although The External Disaster Response Plan was activated within the first few hours, it was not fully implemented. Two primary care teams from the Tarajal and Otero primary care centers were mobilized. Four 061 units, including one basic life support unit, operated at the scene alongside the Spanish Red Cross, which provided 2 ambulances and 6 volunteers trained in first aid. Ten cases of cardiorespiratory arrest were treated to within the first few hours. Patients with less severe injuries were referred to primary care centers. In addition, a 061 unit was stationed at the hospital entrance to perform preliminary triage.

The Tarajal and Otero primary care centers extended their opening hours and received additional physicians, nurses, reception staff, and security personnel. The SUAP received additional nursing support during the night shift. At the hospital, emergency department teams were reinforced with physicians, nurses, and nursing assistants, while pediatric specialists and administrative personnel were also brought in. Security staffing was increased as well. These measures made it possible to maintain routine health care services for the resident population simultaneously.[4,5]

The greatest pressure on health care services occurred during the first 48 hours. Between July 31 and August 1, more than 1,100 patient encounters were recorded within a 20-hour period.[6] From August 2 onward, overall demand progressively declined, with stabilization of out-of-hospital activity and a shift in health care demand toward inpatient units. Initial management at the primary care level and preliminary triage performed by the 061 service helped prevent prolonged hospital overcrowding. No deaths were recorded in public healthcare facilities during the response period analyzed (Figure 1).

This experience demonstrates that having a specific response plan is necessary but insufficient.[7] The World Health Organization recommends anticipating mass arrivals, ensuring the timely availability of information, and strengthening surge response capacity for large influxes of refugees and migrants.[8,9] In Ceuta, insufficient coordination of information within the first few hours hindered full activation of the protocols



Nota metodológica: Los periodos 30–31 Jul (28 h) y 31 Jul–1 Ago (20 h) no cubren 24 horas completas. Para permitir la comparación temporal, se calculó el total de asistencias equivalente a 24 h aplicando el factor 24/horas efectivas del periodo: 28 h → ×0,857; 20 h → ×1,2; 24 h → ×1.
Los valores de Atención Primaria y Especializada mostrados corresponden a los totales brutos observados en cada periodo.

Figure 1. Trends in health care demand and hospital admissions during the crisis, July 30–August 6.

and contributed to an initially reactive response. Establishing permanent early warning communication channels among security forces, intelligence services, and the health care system should therefore be a priority.

Decentralizing demand for health care was another decisive factor. Referring less severe cases to primary care centers and performing triage at the hospital entrance made it possible to preserve hospital capacity for patients who genuinely required hospital-level care. This highlights the importance of triage and the coordinated organization of patient care pathways as essential components of an effective response to mass-casualty incidents.[10,11]

Lampedusa, the Canary Islands, and Ceuta represent 3 migration routes into Europe. Comparing their health care models helps identify the factors determining the resilience of border healthcare systems. The experience of Lampedusa illustrates the difficulties faced by enclaves without a referral hospital that depend on medical evacuations to the mainland.[12] In the Canary Islands, by contrast, migratory pressure is structural and sustained, with substantial differences in healthcare capacity between islands and cumulative pressures on healthcare services.[13] Ceuta, meanwhile, was able to manage most of the demand internally because of the proximity of its health care facilities and the availability of a referral hospital. However, the incident demonstrated that infrastructure alone cannot replace planning, early warning systems, or sufficient health care staffing.

The experience identified 4 priority operational needs: establishing a shared information system to facilitate early activation of the response plan; maintaining structured standby reserves of personnel, vehicles, and equipment; providing coordination bodies with real-time management tools and a clearly defined health care command structure; and integrating mental health care, epidemiological surveillance, immunization, and interventions addressing the social determinants of health alongside acute injury management from the outset.[14,15]

In conclusion, Ceuta's health care response within the first 7 days of the mass arrival in July 2026 demonstrated considerable adaptability. Organizational flexibility, extraordinary reinforcement of health care services, and management of demand in out-of-hospital settings helped prevent prolonged hospital overcrowding. However, delays in fully activating the specific response plan, the initial mismatch between demand and available resources, and insufficiently integrated coordination revealed significant vulnerabilities. Preparedness for future migration crises must be based on early warning systems, specific protocols, structured resources, and a comprehensive health care response. Such preparedness cannot be improvised once an incident has already begun. After the first 7 days, the focus of health care progressively shifted from emergency care toward the ongoing management of traumatic injuries and screening for infectious diseases. This evolution demonstrates that the health care response to mass arrivals does not end when the initial surge subsides but requires the capacity to ensure continuity of care and address public health needs and the healthcare needs of migrants during subsequent phases.

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