



Libya

WUENIC 2025 revision,
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WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2025 revision

Every year, WHO and UNICEF jointly review submissions from Member States on national immunization coverage, including annual administrative and official coverage, finalized survey reports and data from both published and grey literature. The data is triangulated with consideration of potential biases and local expert opinions to differentiate between accurately reflective empirical data and potentially misleading data, to assess the most likely coverage levels for each country.

WHO and UNICEF produce country-specific estimates by reviewing each country's data independently, without borrowing from other countries when data are missing. The estimates are not ad hoc adjustments to reported figures and may rely on a single empirical source, typically nationally reported coverage. When no data exist for a specific country-vaccine-year, earlier and later data are interpolated. If sources conflict or vary widely, the most plausible estimate is selected after considering potential biases.

This slide deck presents the latest WUENIC estimates (published 15 July 2026), using UNPD World Population Prospects (WPP 2024) for population-weighted averages and to derive absolute numbers of vaccinated and unvaccinated/zero-dose children.

Methods: • [Burton et al. 2009. WHO and UNICEF estimates of national infant immunization coverage: methods and processes.](#)

- [Burton et al. 2012. A formal representation of the WHO and UNICEF estimates of national immunization coverage: a computational logic approach.](#)
- [Brown et al. 2013. An introduction to the grade of confidence used to characterize uncertainty around the WHO and UNICEF estimates of national immunization coverage.](#)
- [Danovaro-Holliday et al. 2021. Compliance of WUENIC with Guidelines for Accurate and Transparent Health Estimates Reporting \(GATHER\) criteria.](#)

Definitions of immunization terms

Vaccine coverage

Percentage of infants (children under one year of age) who received certain vaccine-doses. For example, coverage of DTP3 is the percentage of infants who received all three doses of diphtheria, tetanus, and pertussis (DTP) vaccine.

Unvaccinated

An infant that did not receive the first dose of a vaccine series. The term zero-dose is used to describe children unvaccinated with DTP1.

Under-vaccinated

An infant who received some but not all the recommended vaccine-doses in the national schedule.

Vaccine-Doses

- Bacillus Calmette-Guerin (BCG): vaccine against tuberculosis
- Hepatitis B birth dose, given within 24 hours after birth (HepBB)
- Diphtheria, tetanus, and pertussis vaccine, first dose (DTP1) and third dose (DTP3)
- Hepatitis B vaccine, third dose (HepB3)
- Haemophilus influenzae type b vaccine, third dose (Hib3)
- Inactivated polio vaccine, first dose (IPV1) and last dose (IPVC)
- Measles containing vaccine, first dose (MCV1) and second dose (MCV2)
- Rotavirus vaccine, last dose (RotaC)
- Pneumococcal vaccine, last dose (PCVC)
- Yellow Fever vaccine (YFV)
- Meningococcal A vaccine (MengA)
- Human papillomavirus vaccine, first dose (HPV1) and last dose (HPVc): vaccine to protect against certain types of human papillomavirus that can lead to cancer or genital warts

The Immunization Agenda 2030 (IA2030)

The IA2030 is a global strategy endorsed by the World Health Assembly aiming to ensure everyone, everywhere, at every age benefits from vaccines for improved health and well-being by 2030. It focuses on increasing vaccine coverage, equity, sustainability and pandemic preparedness while promoting life-course immunization and integrating immunization with other health services.

Key concepts

- The World Health Organization (WHO) provides global vaccine recommendations, which are adapted by countries based on local needs. Only DTP, polio and measles-containing vaccines are used in all countries.
- DTP1 is a marker of access to routine immunization services, and when not received, serves as a proxy for identifying children who have not received any vaccinations, also known as "zero-dose" children. High DTP1 coverage indicates good access to immunization services, while low coverage suggests challenges in reaching children with essential vaccines.
- DTP3 is a widely used indicator of immunization programme performance. It reflects a country's ability to deliver routine immunization services and ensures children are protected against serious disease. DTP3 is tracked globally and serves as a key measure of a nation's vaccination efforts.
- DTP1-DTP3 drop-out measures the percentage of children who received DTP1 but not DTP3, and highlights where children are lost along the vaccination pathway, highlighting potential weaknesses in service delivery and follow-up.
- MCV1 (usually recommended between 9-12 months) assesses the ability to deliver vaccines later in infancy. It serves as a tracer for protection against measles and is a good indicator of health system performance.
- HPV vaccine protects against specific types of human papilloma virus (HPV), and is used to measure life cycle vaccination.
- Other key indicators include PCVC and MCV2, which are used to monitor the Sustainable Development Goals (SDGs).
- Together, these indicators provide a consistent and comparable way to track immunization progress, identify missed communities and monitor global targets, including those under the Immunization Agenda 2030 (IA2030) and Sustainable Development Goals (SDGs).

Key messages

- DTP1 coverage increased 7 percentage points from 90% in 2024 to 97% in 2025.
- DTP3 coverage increased 4 percentage points from 86% in 2024 to 90% in 2025.
- There were 8,000 fewer zero-dose children in 2025. This leaves 4,000 children without vaccination, vulnerable to vaccine-preventable diseases and a further 8,000 with incomplete protection.
- Libya accounted for 0.3% of zero-dose children in Middle East and North Africa (MENA) and <0.1% of zero-dose children globally.
- MCV1 coverage increased 4 percentage points from 89% in 2024 to 93% in 2025. There were 8,000 children who missed out on the first measles vaccination.
- MCV2 coverage increased 5 percentage points from 80% in 2024 to 85% in 2025.
- Last dose coverage of HPV vaccination (HPVc) among girls remained constant at 28% in 2025.

Vaccination schedule, 2025

Level	Vaccine	Dose number and age administered			
		1	2	3	4
National	BCG	Birth			
National	DTAPHIBHEPBIPV	2 months	4 months	6 months	
National	DTAPHIBIPV (booster)				18 months
National	HEPB (pediatric)	Birth			
National	HPV (females)	12 years	+2 months	+4 months	
National	MMR	12 months	18 months		
National	OPV	Birth	9 months		
National	PCV	2 months	4 months	12 months	
National	Rotavirus	2 months	4 months	6 months	

This table shows the 2025 national immunization schedule for routine services in Libya, reported through the WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Each row corresponds to a vaccine or combination vaccine, indicating whether it is delivered at the national or subnational level. The schedule outlines the number of doses and the recommended ages for administration. Only childhood and adolescent vaccines relevant to WUENIC are included.

Vaccine introduction years

Vaccine	National introduction
HPV (Human papillomavirus) vaccine	2013
HepB birth dose	1998
Hepatitis B vaccine	2000
Hib (Haemophilus influenzae type B) vaccine	2007
IPV (Inactivated polio vaccine)	2014
IPV (Inactivated polio vaccine) 2nd dose	2014
Malaria vaccine	Not introduced
Measles-containing vaccine 2nd dose	1995
Meningococcal meningitis vaccines (any strain)	2008
Mumps vaccine	1996
PCV (Pneumococcal conjugate vaccine)	2013
RSV (Respiratory syncytial virus) immunization strategy	Not introduced
Rotavirus vaccine	2013
Rubella vaccine	1993
Typhoid conjugate vaccine	Not introduced

This table displays the year each vaccine was introduced in Libya. If a vaccine has been suspended, no introduction year is shown, but if it was suspended and later reintroduced, the year of reintroduction is provided. The introduction years can reflect nationwide rollout, partial (subnational) rollout, or introduction targeted to specific risk groups or high-risk areas, as indicated in the column headers.

Vaccine stockouts

Vaccines / supplies	2021	2022	2023	2024	2025
BCG	National (2m) and subnational	National (3m) and subnational	National (6m) and subnational	National (3m) and subnational	National (2m) and subnational
DTP-Hib-HepB-IPV			National (6m) and subnational		
DTP-Hib-IPV			National (6m) and subnational		
DTP-containing vaccine	National (2m) and subnational	National (3m) and subnational			
HPV	National (2m) and subnational	National (12m) and subnational			
HepB		National (3m) and subnational	National (6m) and subnational		
Hib		National (3m) and subnational			
IPV	National (2m) and subnational	National (3m) and subnational			
MCV	National (2m) and subnational	National (3m) and subnational			
Measles-Mumps-Rubella (MMR)			National (6m) and subnational		
MenA			National (6m) and subnational		National (2m) and subnational

This table presents reported vaccine stockouts of childhood vaccines relevant to WUENIC at the national and subnational levels over the last 5 years (2021 to 2025). Where available, the duration of national-level stockouts is indicated in months. Subnational stockouts are noted without specifying duration. Only vaccines that had a stockout during the specified time period are displayed.

A stockout refers to a period when vaccine storage and distribution points (e.g., national or district stores) are fully depleted, including buffer stock, and are unable to supply vaccines to lower-level stores or facilities. It is important to note that facility-level stockouts can still occur even when upper-level stores have inventory. Stockouts, especially prolonged ones, can negatively impact immunization coverage.

In 2025, coverage increased for 11 antigens, remained unchanged for two, and declined for none, indicating overall progress in routine immunization performance; 10 achieved at least 90% coverage.

Vaccine coverage, Libya, 2000-2025

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
BCG	98	99	99	99	99*	99	99	99	99	99	99	99	99	99	99	99	99	99	74*	74*	74	74*	74*	74*	85*	97*
DTP1	97	96	97	99	99*	98	98	98	98	98	98	99	99	98	96	98	98	99	74*	74*	74	74*	74*	74*	90	97
DTP3	94	94	93	95	97*	98	98	98	98	98	98	98	98	96	94	97	97	97	73*	73*	73	73*	73*	73*	86	90
Hib3								56	98	98	98	98	98*	96	94	97	97	97	73*	73*	73	73*	73*	73*	86	90
HepB3	92	93	91	96	99*	97	98	98	98	98	98	98	98*	96	94	97	97	97	73*	73*	73	73*	73*	73*	86	90
PCVC															39	71	96	95	72	73	73	73	73	73	89	92
RotaC															86	93	97	97	73*	73*	73	73*	73*	73*	82	86
IPV1																98	98	99	74*	74*	74	74*	74*	74*	90	90
IPVC																						73	73	73	86	90
MCV1	93	93	91	96	99	97	98	98	98	98	98	98	98	96	93	98	97	95	73*	73*	73	73*	73*	73*	89	93
RCV1	93	93	91	96	99	97	98	98	98	98	98	98	98	96	93	98	97	95	73	73	73	73	73	73	89	93
MCV2		81	86	90	95	95	96	97	97	97	97	97	97	95	92	97	96	94	72*	72*	72	72*	72*	72*	80	85
HPVc																								30	28	28



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision.
Note: Stock information available from 2003.
An asterisk (*) indicates where there was a vaccine stockout at the national or subnational level.

This heatmap shows trends in vaccine coverage since 2000, with green cells indicating coverage of 90% or more.

In 2025, 10 out of 13 (77%) vaccines in the schedule achieved coverage of 90% or more. Vaccine coverage ranged from 85% to 97%.

Since 2001, estimates have been made for 7 new vaccines. HPVc is the newest vaccine reported (2023), which achieved 28% coverage in 2025.

In 2025, Libya reported stockouts of vaccines/supplies (BCG, MenA, and OPV) (more information on slide 8).

Coverage of key childhood vaccines (%), Libya, 2000-2025



This chart shows coverage trends for the DTP and measles vaccines. These are key antigens for assessing national immunization programmes.

In 2025, DTP1 coverage (a proxy for access to immunization services) was 93%.

DTP3 coverage - a marker of how well countries are delivering immunization services to children - achieved the 90% target.

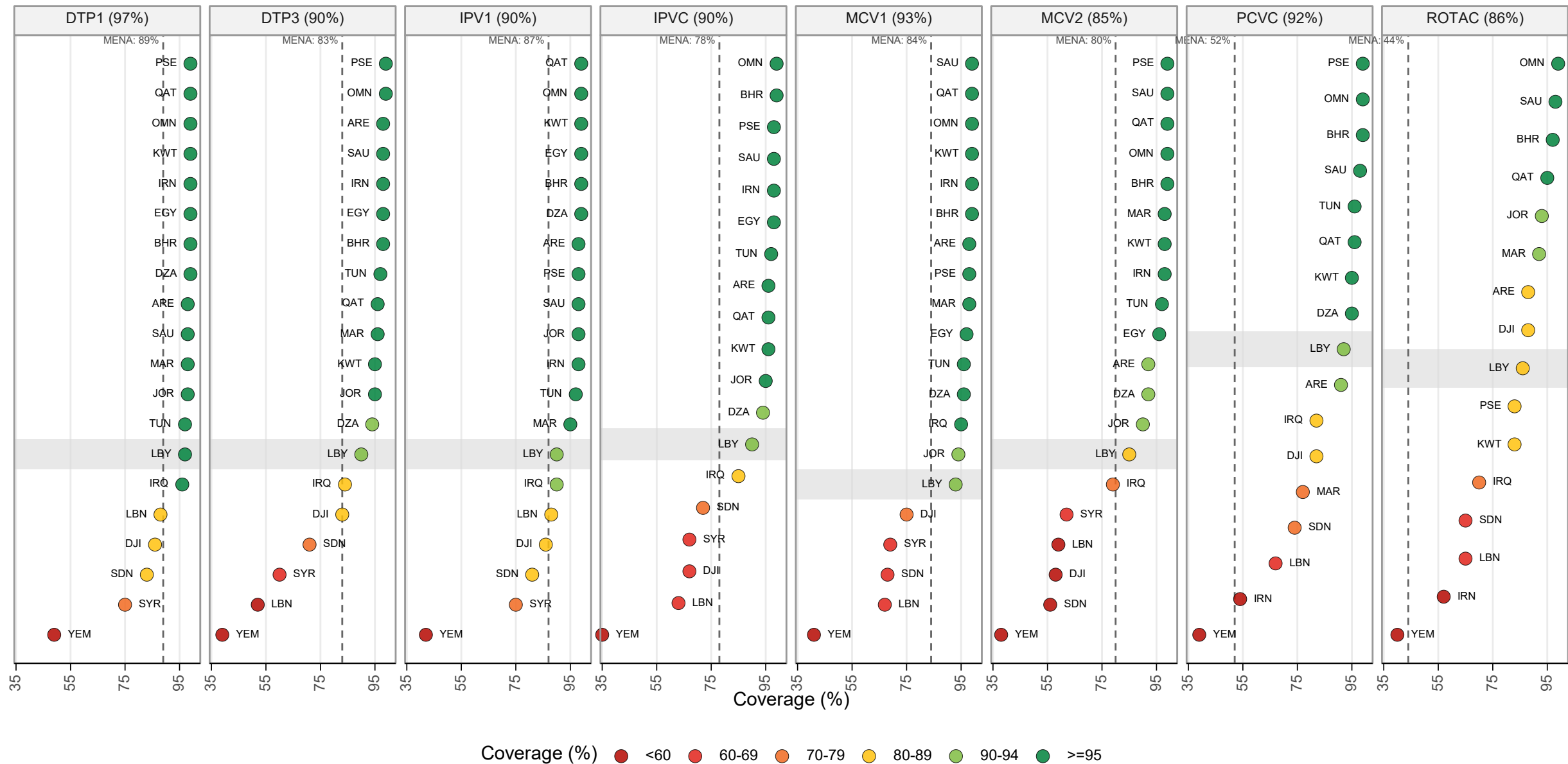
WHO recommends that countries achieve at least 95% coverage with both the first (MCV1) and second (MCV2) doses of measles-containing vaccine. MCV1 provides initial protection and MCV2 ensures long-term immunity and closes gaps in coverage.

In 2025, MCV1 coverage was below, but close to the 95% target and MCV2 coverage was below the 95% target.

Between 2024 and 2025, 4 vaccines increased coverage, 0 declined and 0 remained the same.

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision

Vaccine coverage compared with other countries in the region, MENA, 2025



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Country ISO codes displayed. Coverage in lby shown in the headers. Regional average coverage shown by the dashed line.

DTP1

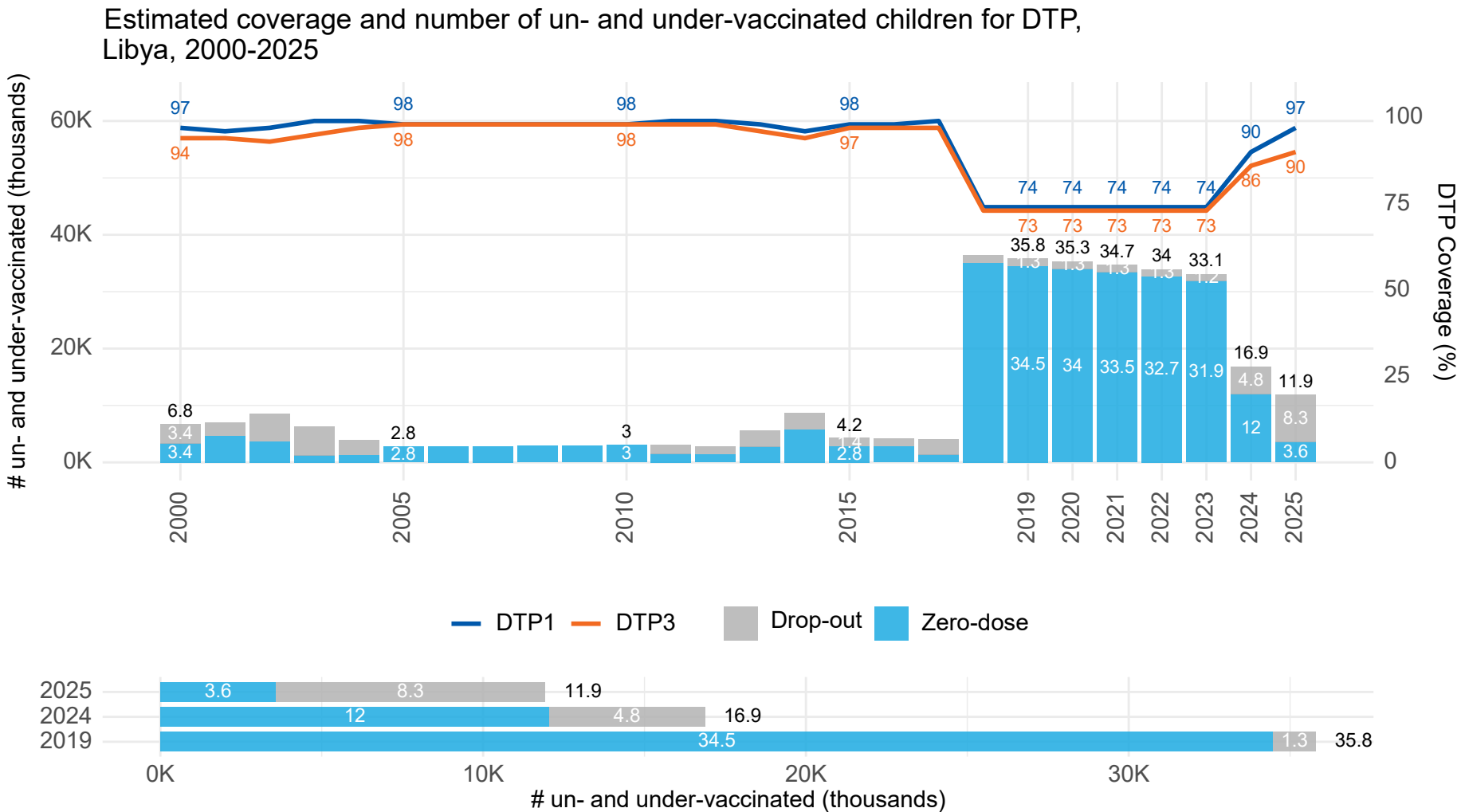
In 2025, DTP1 coverage was 97% and DTP3 was 90%, leaving 12,000 children un- or under-vaccinated, including 4,000 zero-dose and 8,000 with only partial protection.

The key goal of the Immunization Agenda 2030 is to make vaccination available to everyone, everywhere, by 2030.

This chart shows diphtheria, tetanus and pertussis-containing vaccine first (DTP1) and third dose (DTP3) coverage trends, the number of zero-dose children and DTP drop-out in Libya.

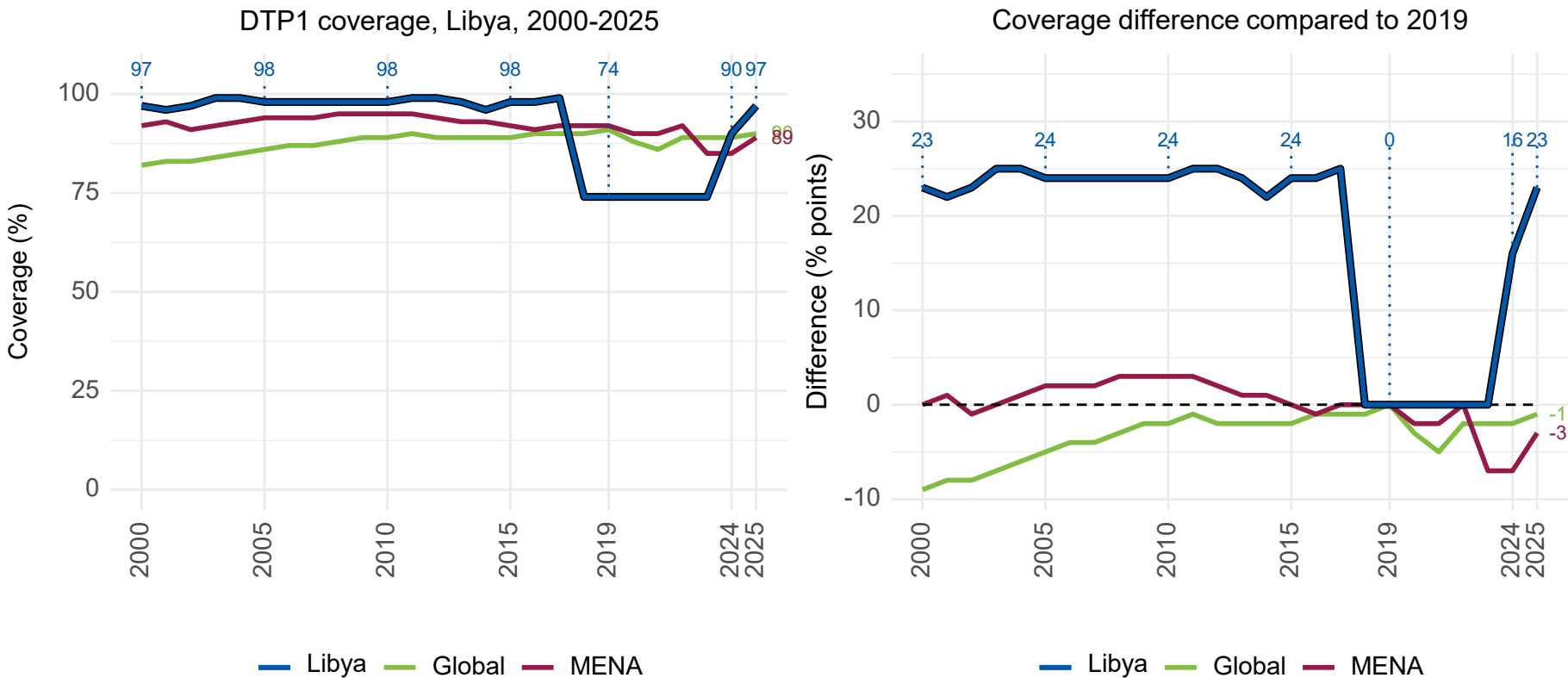
In 2025, DTP1 coverage in Libya increased to 97%. The number of children missing out on any DTP vaccination (zero-dose children) improved from 12,000 in 2024 to 4,000 in 2025.

DTP3 coverage increased to 90% in 2025, leaving 12,000 children vulnerable to vaccine-preventable diseases.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Lines show vaccine coverage and bars show number of children.
Zero-dose children are those who did not receive DTP1.

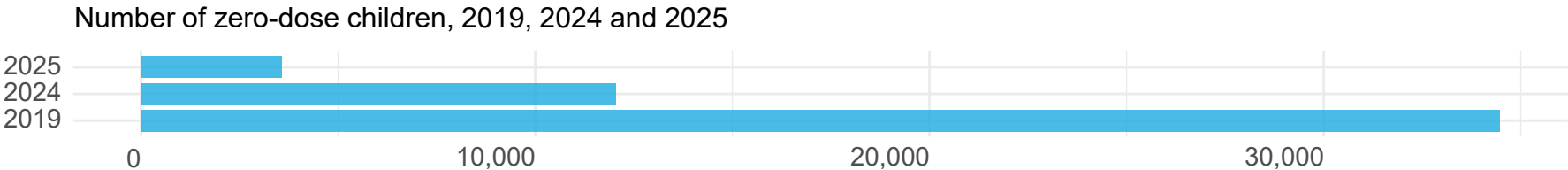
In 2025, Libya DTP1 coverage was 97% - this is 23 percentage points higher than in 2019 and higher than both the global and regional averages.



In 2025, DTP1 coverage in Libya (97%) was 7 percentage points higher than the global average (90%) and 8 percentage points higher than the average across all MENA countries (89%).

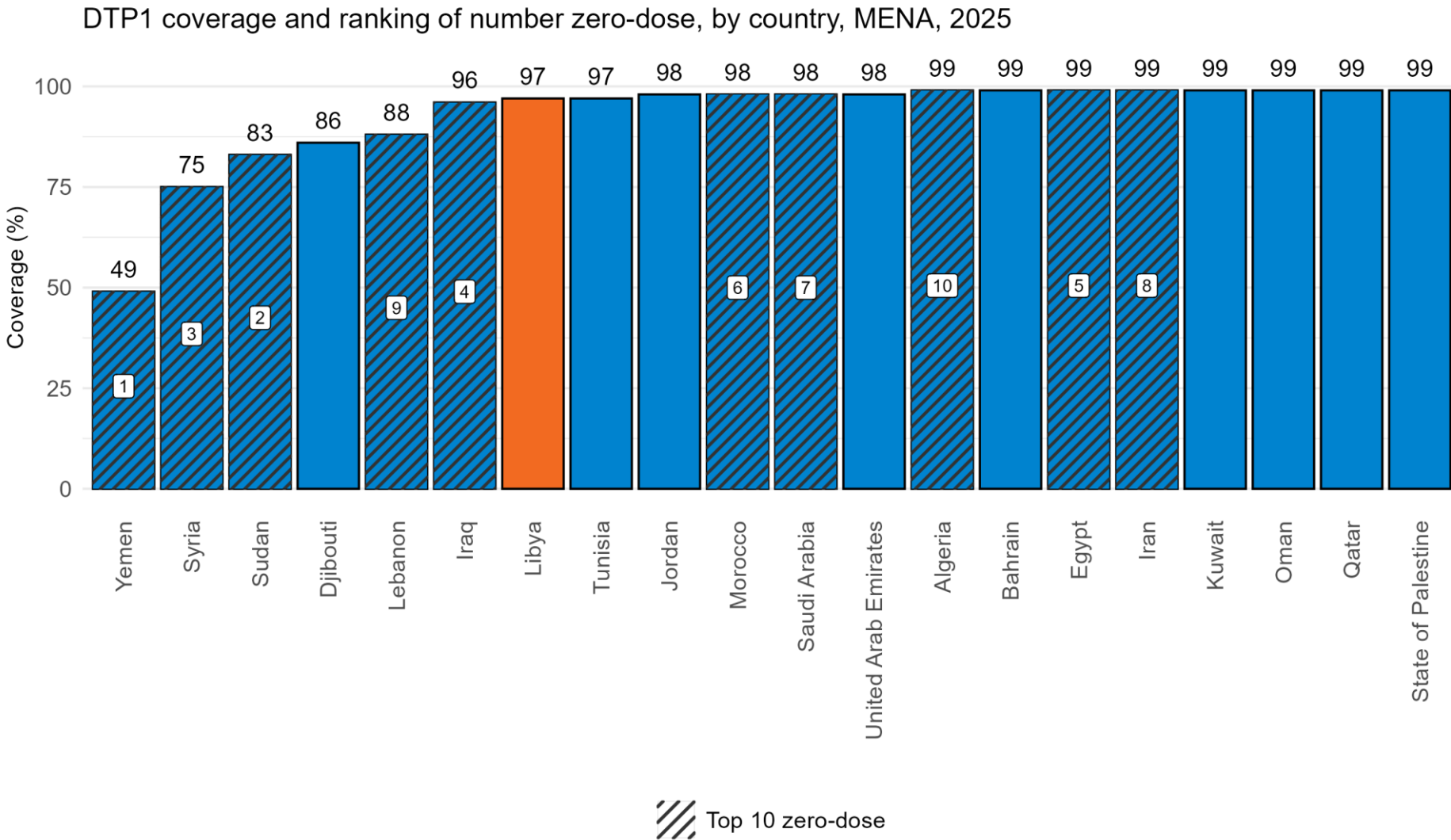
National DTP1 coverage was 23 percentage points higher than in 2019 (74%).

This equates to 4,000 zero-dose children in 2025 compared to 34,000 zero-dose children in 2019.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Coverage difference compared to 2019 - values above zero indicate coverage higher than in 2019 and values below zero indicate coverage lower than in 2019

In 2025, Libya was among the countries with the highest coverage and was not among the top 10 countries with the highest number of zero-dose children in the region.



This chart shows DTP1 coverage in countries in MENA from lowest to highest coverage, and the rank of the top 10 countries with the most zero-dose children, based on absolute numbers.

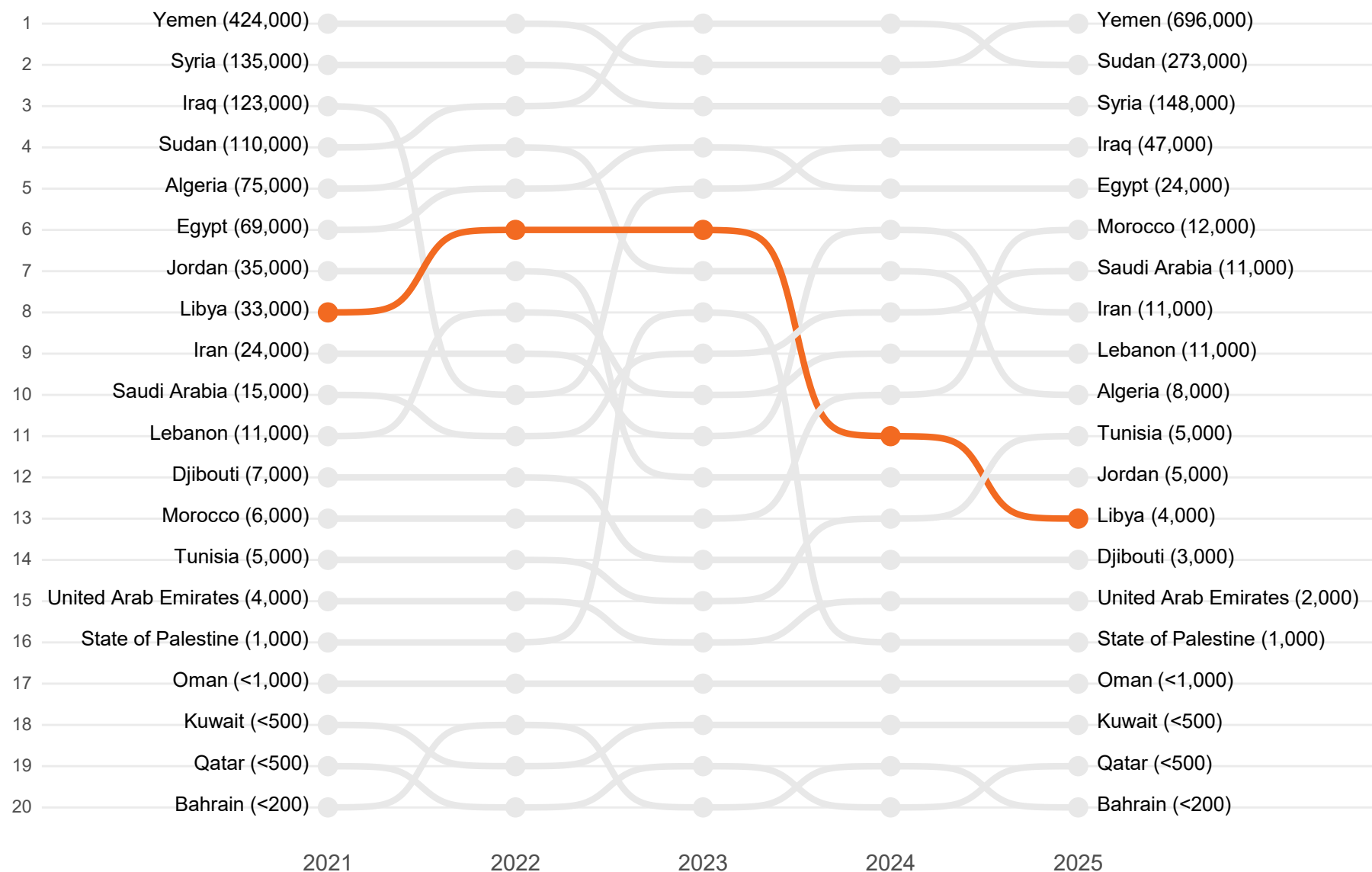
In 2025, Libya ranked number 7 out of 20 countries for lowest DTP1 coverage (based on tied ranks).

Libya was not in the top 10 countries with the most zero-dose children.

Note: Large cohort countries may have high numbers of zero-dose children despite high vaccine coverage. It is important to consider both coverage and absolute numbers of unvaccinated children to ensure vulnerable countries with small birth cohorts are not overlooked.

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Bars are ranked by ascending coverage. Numbers in bubbles display top 10 rank based on absolute number of zero-dose children.

Countries ranked by number of zero-dose children, MENA, 2021-2025



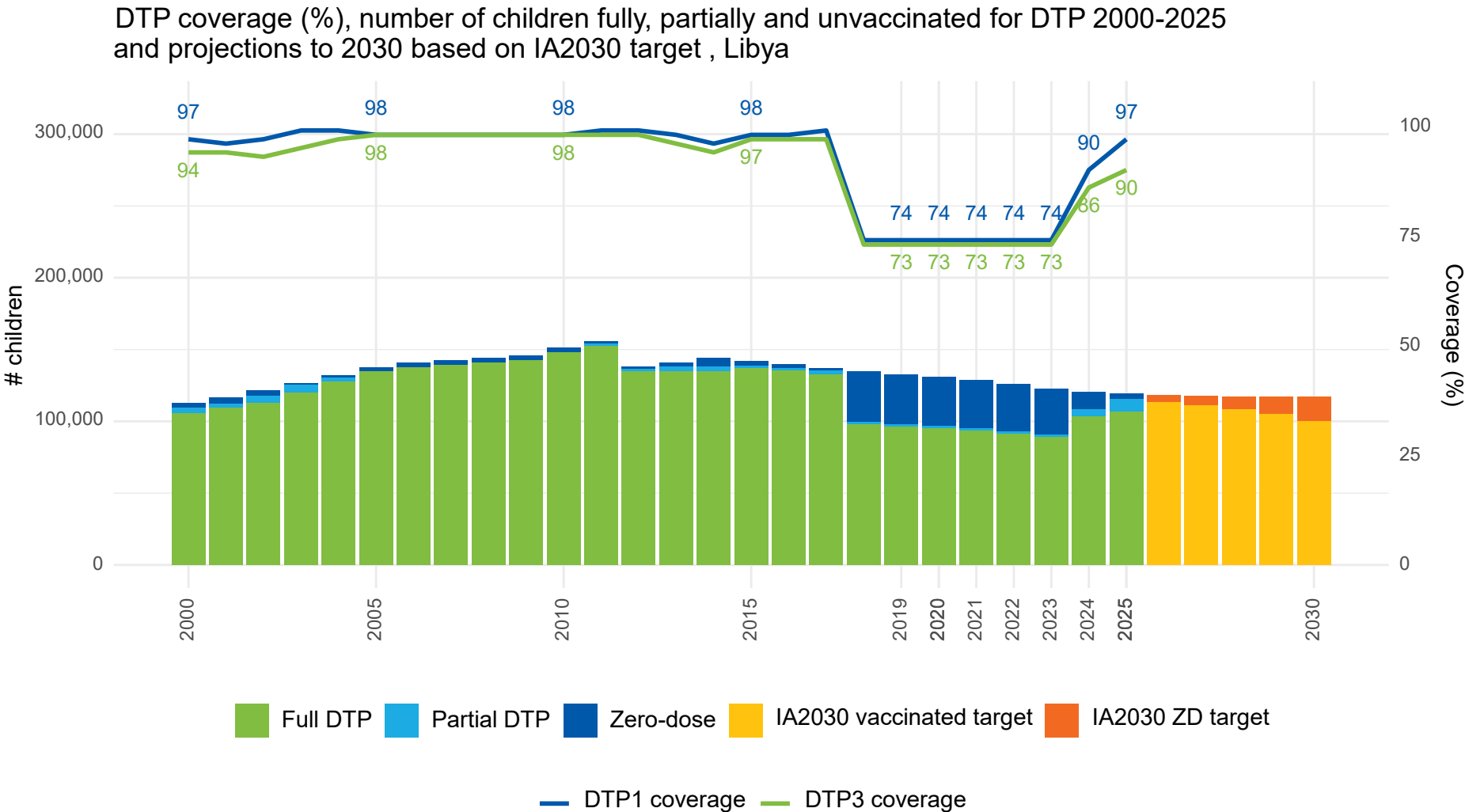
This chart compares the ranking of countries in the region based on the absolute number of zero-dose children, with rank 1 representing the country with the most zero-dose children.

In 2021, Libya ranked number 8 out of 20 countries with 33,000 zero-dose children.

In 2025, Libya ranked number 13 out of 20 countries with 4,000 zero-dose children.

Note: Absolute numbers of zero-dose children is based on a combination of programme performance and surviving infant target population size. Countries may climb to a higher rank despite a decline in number of zero-dose children as the ranking also depends on performance of other countries in the region.

Libya is on track to halve zero-dose children by 2030, but sustaining progress will require continued strengthening of immunization systems.



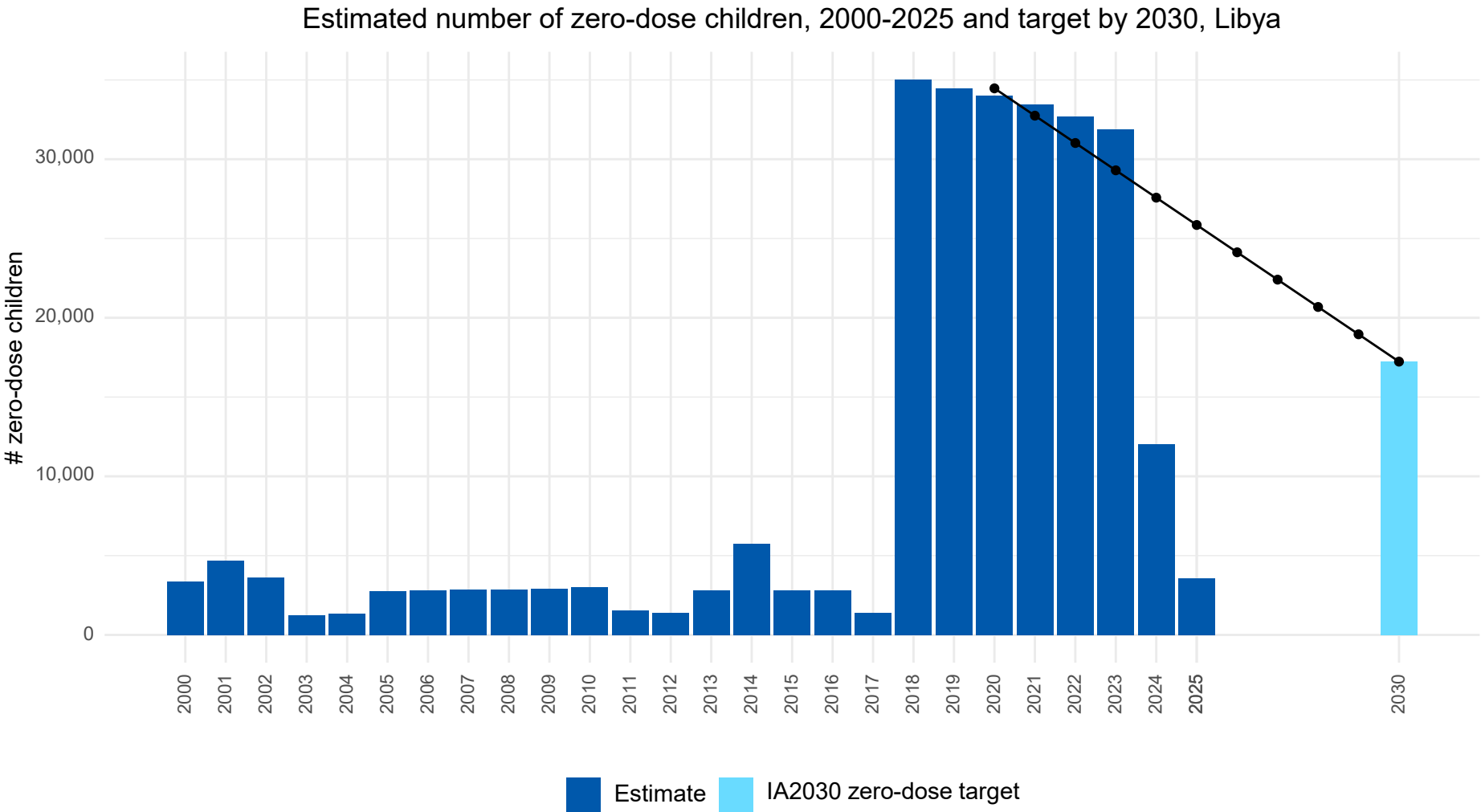
Sources: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision; United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024, Online Edition. Note: The Immunization Agenda 2030 (IA2030) calls on all countries to reduce the number of zero dose children in 2019 by half by 2030.

IA2030 calls on all countries to reduce the number of zero dose children in 2019 by half by 2030. This chart shows the annual number of children required to be vaccinated to reach the ZD target.

IA2030 calls on all countries to reduce the number of zero dose children in 2019 by half by 2030. This chart shows the annual number of children required to be vaccinated to reach the ZD target.

Libya is projected to have a decline in the number of surviving infants by 2030. To achieve the IA2030 ZD target, current efforts would be sufficient, however, countries must strengthen beyond the targets.

In 2025, the number of zero-dose children was 86% below the annual IA2030 goal, positioning the programme to reach, and potentially exceed the 2030 goal if current progress continues.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision

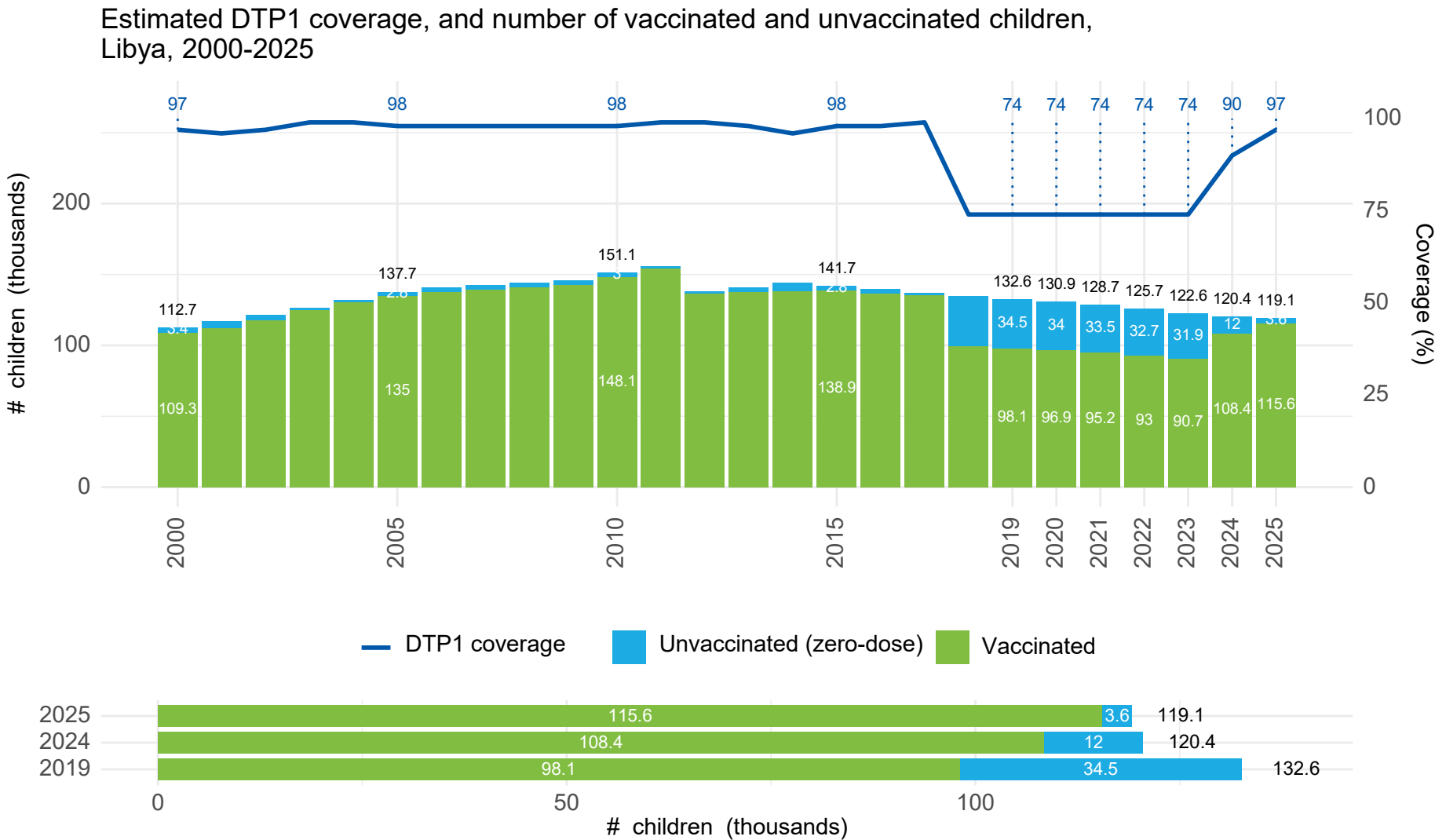
Note: The Immunization Agenda 2030 (IA2030) calls on all countries to reduce the number of zero dose children in 2019 by half by 2030. Dark blue bars are the estimated number of zero-dose children in 2000-2025, light blue bar is the target number of zero-dose children by 2030. The line and points show the yearly progress and trajectory to meet the target by 2030, based on a linear decline.

IA2030 aims to leave no one behind with immunization and calls on all countries to reduce the number of zero dose children by half by 2030.

- This chart shows:
- Estimated number of zero-dose children in 2000-2025 (dark blue bars)
 - Zero-dose target by 2030 (light blue bar)
 - Trajectory to reach the 2030 target based on a linear decline (points)

In 2025, the number of zero-dose children was approximately 86% lower than (ie. the country had achieved) the annual number proposed to reach the target, based on a linear trajectory of decline.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision

DTP1 coverage in 2025 (97%) was higher than in 2019 (74%).

The number of children vaccinated with DTP1 increased 18% compared to in 2019.

The number of surviving infants decreased approximately 10% compared to in 2019.

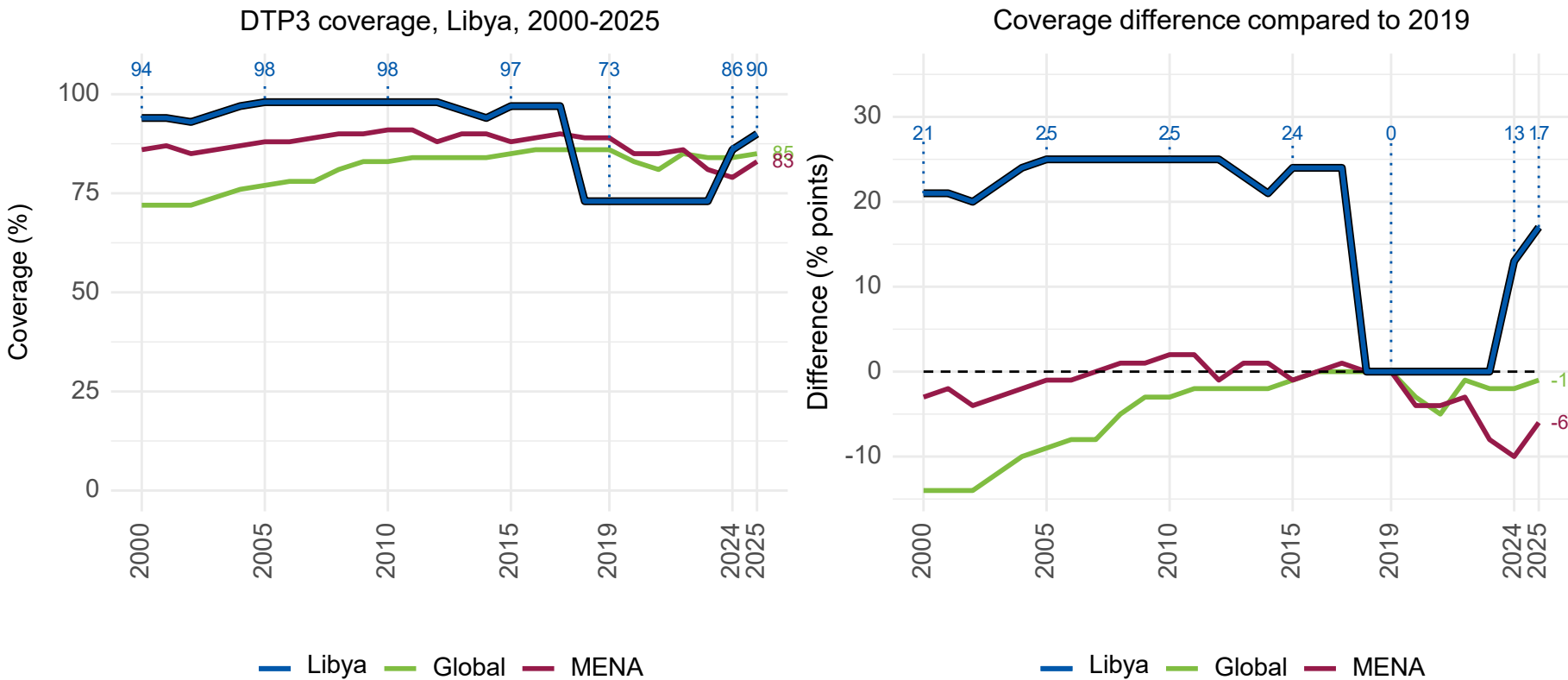
In 2025, more children were vaccinated than in 2019.

In 2025, there were fewer surviving infants (target population) than in 2019.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.

DTP3

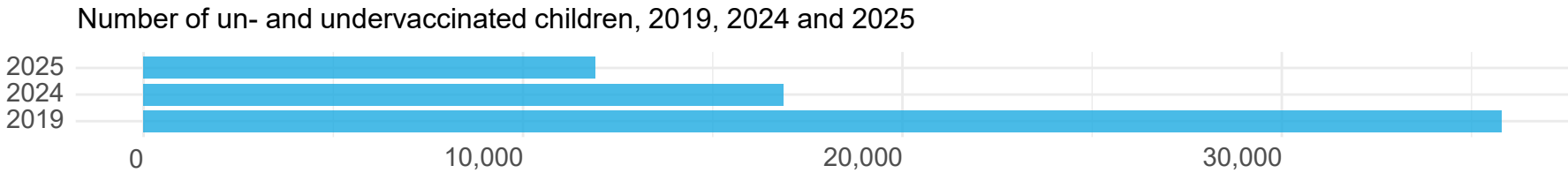
In 2025, Libya DTP3 coverage was 90% - this is 17 percentage points higher than in 2019 and higher than both the global and regional averages.



In 2025, DTP3 coverage in Libya (90%) was 5 percentage points higher than the global average (85%) and 7 percentage points higher than the average across all MENA countries (83%).

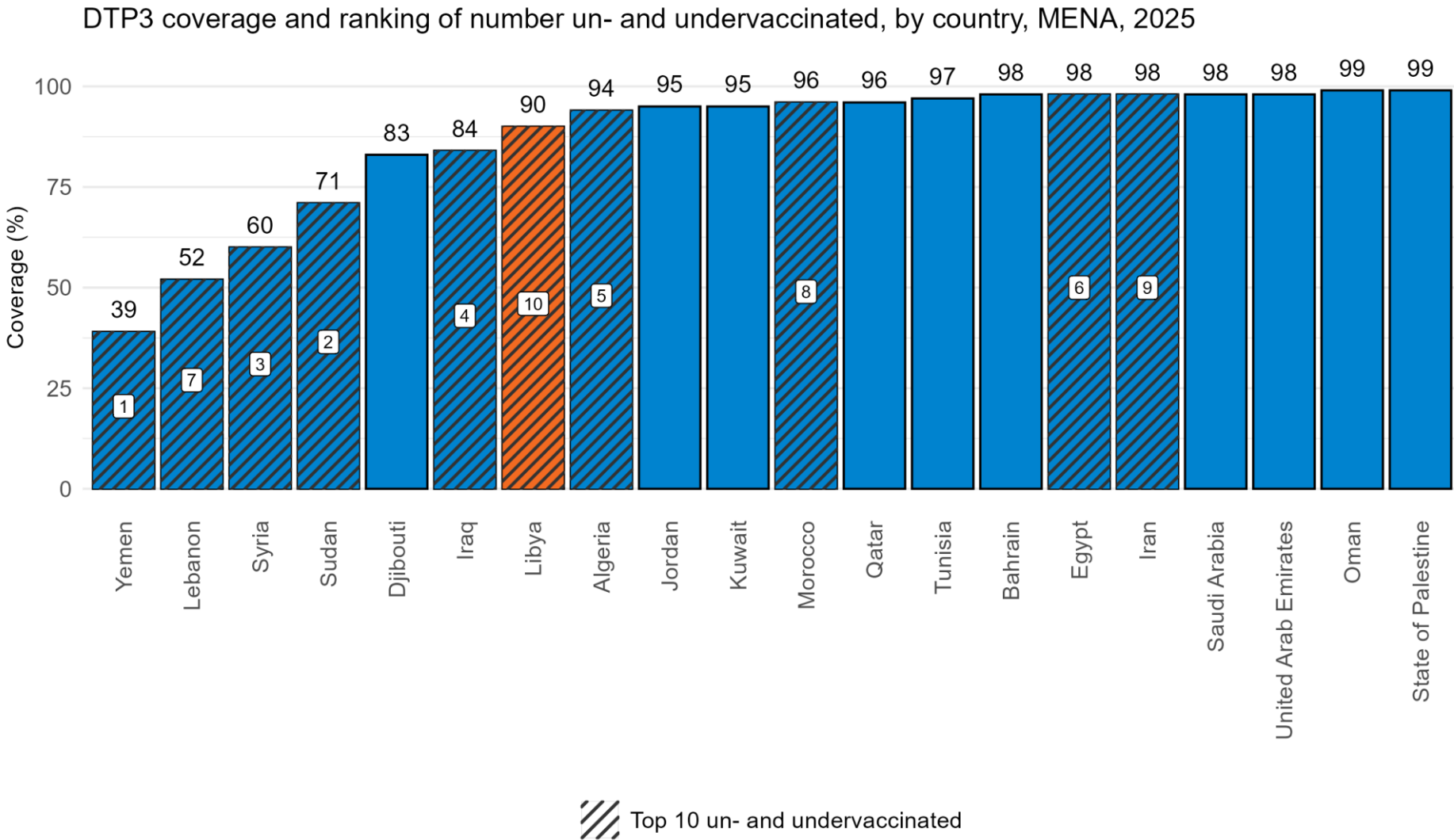
National DTP3 coverage was 17 percentage points higher than in 2019 (73%).

This equates to 12,000 un- and undervaccinated children in 2025 compared to 36,000 un- and undervaccinated children in 2019.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Coverage difference compared to 2019 - values above zero indicate coverage higher than in 2019 and values below zero indicate coverage lower than in 2019

In 2025, Libya was among the countries with the highest coverage, but in the top 10 countries with the highest number of un- and undervaccinated children in the region.



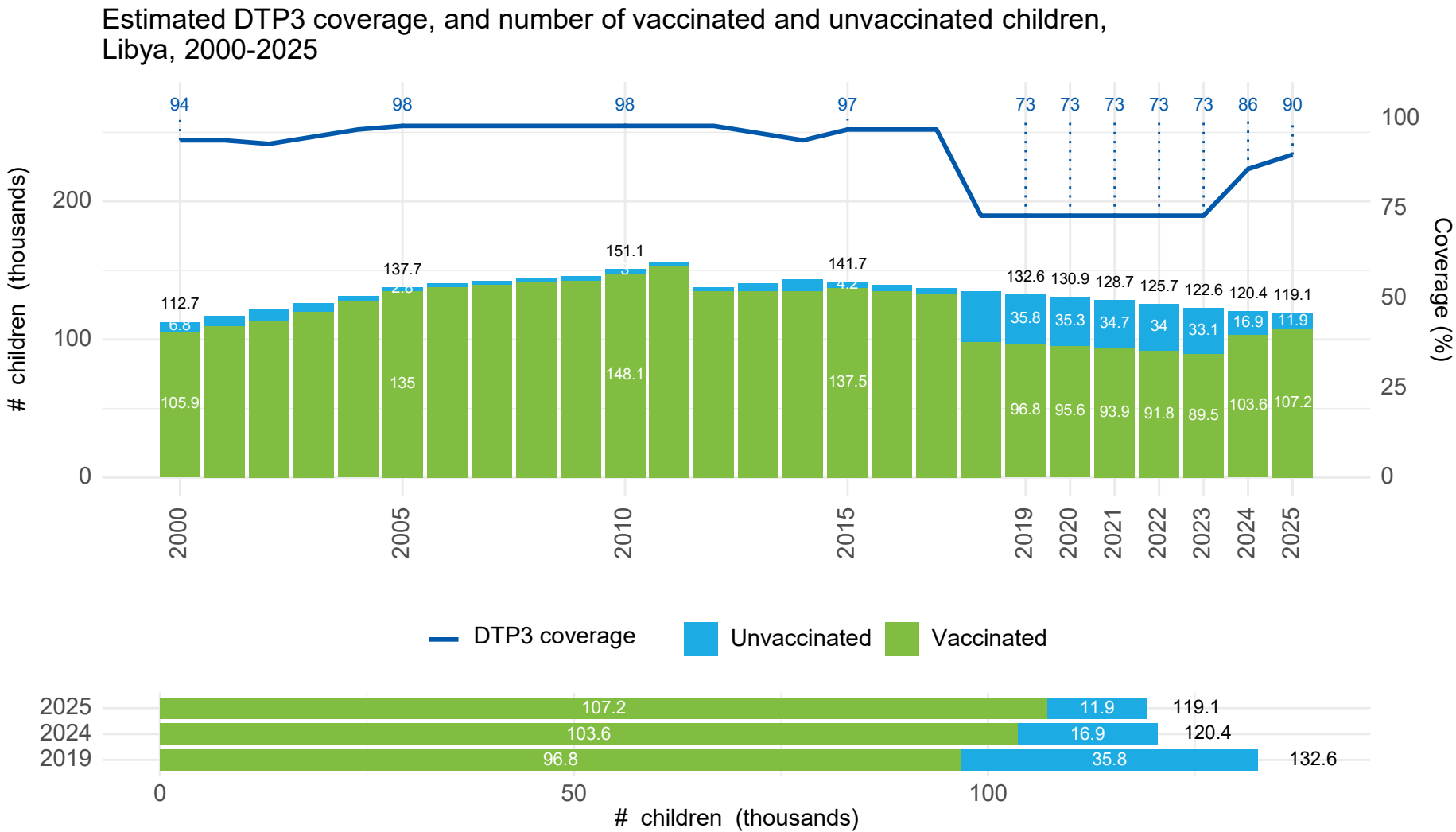
This chart shows DTP3 coverage in countries in MENA from lowest to highest coverage, and the rank of the top 10 countries with the most un- and undervaccinated children, based on absolute numbers.

In 2025, Libya ranked number 7 out of 20 countries for lowest DTP3 coverage (based on tied ranks).

Libya was in the top 10 countries with the most un- and undervaccinated children (rank=10).

Note: Large cohort countries may have high numbers of un- and undervaccinated children despite high vaccine coverage. It is important to consider both coverage and absolute numbers of unvaccinated children to ensure vulnerable countries with small birth cohorts are not overlooked.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Unvaccinated includes zero-dose and undervaccinated children

DTP3 coverage in 2025 (90%) was higher than in 2019 (73%).

The number of children vaccinated with DTP3 increased 11% compared to in 2019.

The number of surviving infants decreased approximately 10% compared to in 2019.

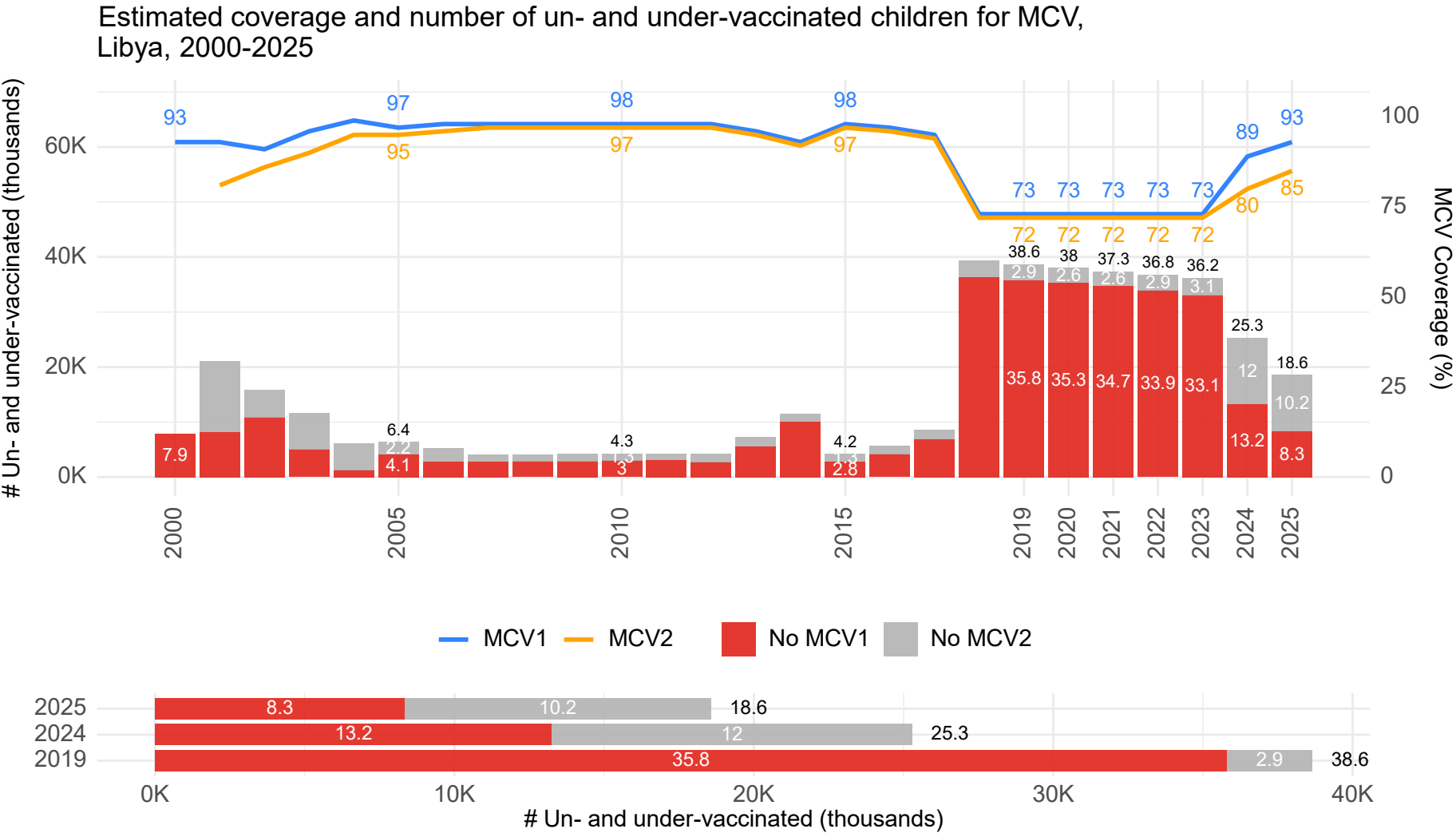
In 2025, more children were vaccinated than in 2019.

In 2025, there were fewer surviving infants (target population) than in 2019.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.

MCV1

MCV1 coverage increased to from 89% in 2024 to 93% in 2025 - below the 95% level needed to prevent outbreaks and, leaving 8,000 children without any protection against measles. MCV2 coverage increased to from 80% in 2024 to 85% in 2025 - below the IA2030 target of 90%.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Lines show vaccine coverage and bars show number of children.

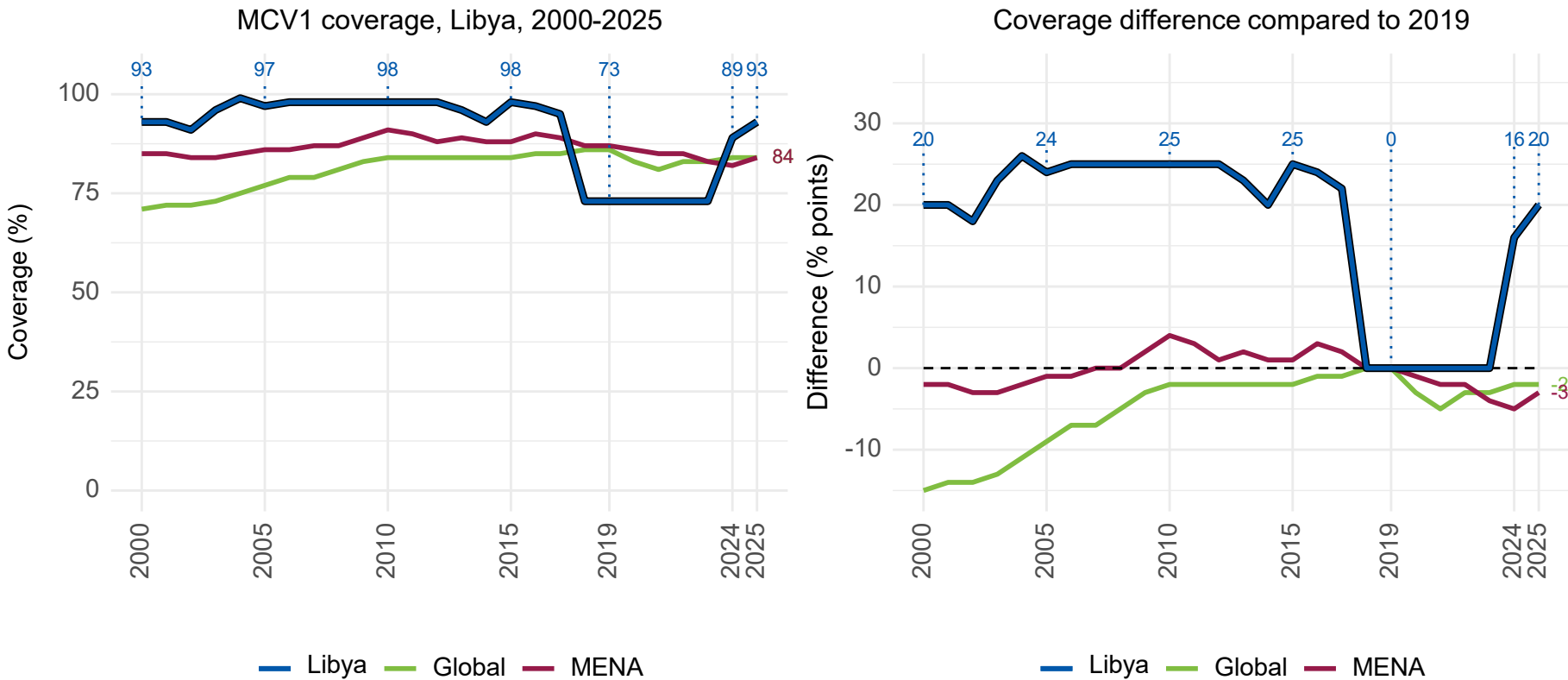
Measles, because of its high transmissibility, acts as a 'canary in the coalmine', quickly exposing any immunity gaps in the population. The coverage of measles containing vaccine (MCV) is thus often used as a tracer for protection.

The percentage of children receiving MCV1 – typically at 9 or 12 months depending on the national vaccination schedule – increased to 93%. This is greater than in 2019, where coverage was 73%.

8,000 children missed their routine first dose of measles vaccine.

MCV2 is typically administered to children between 18 months and five years old. MCV2 coverage increased to 85% in 2025.

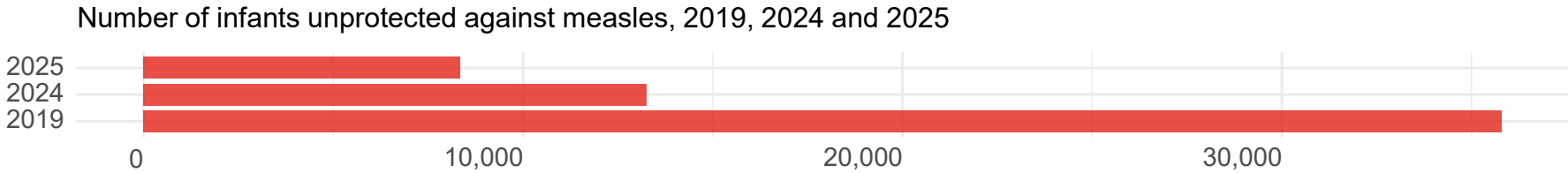
In 2025, Libya MCV1 coverage was 93% - this is 20 percentage points higher than in 2019 and higher than both the global and regional averages.



In 2025, MCV1 coverage in Libya (93%) was 9 percentage points higher than the global average (84%) and 9 percentage points higher than the average across all MENA countries (84%).

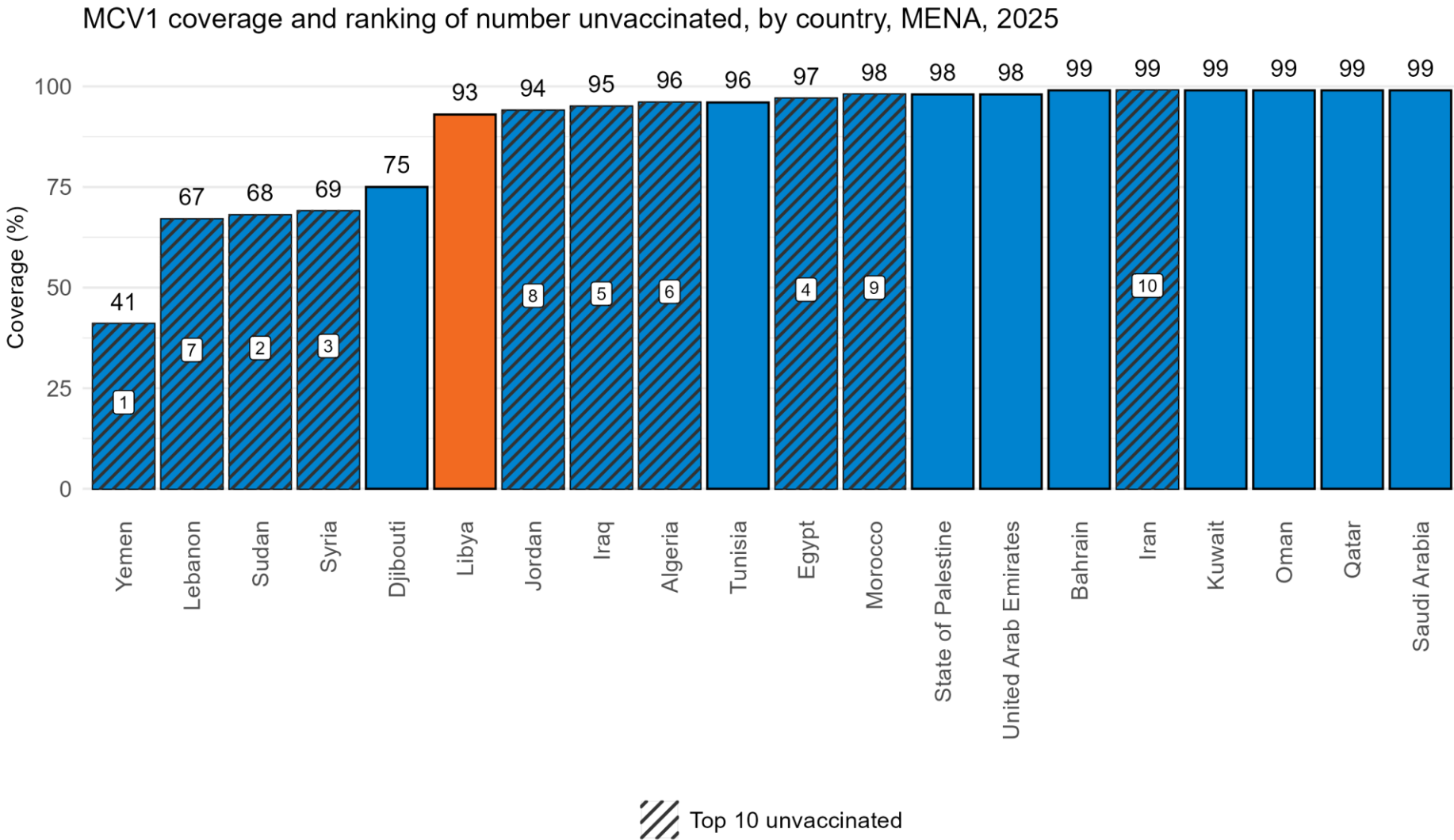
National MCV1 coverage was 20 percentage points higher than in 2019 (73%).

This equates to 8,000 unvaccinated children in 2025 compared to 36,000 unvaccinated children in 2019.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Coverage difference compared to 2019 - values above zero indicate coverage higher than in 2019 and values below zero indicate coverage lower than in 2019

In 2025, Libya was among the countries with the highest coverage and was not among the top 10 countries with the highest number of unvaccinated children in the region.



This chart shows MCV1 coverage in countries in MENA from lowest to highest coverage, and the rank of the top 10 countries with the most unvaccinated children, based on absolute numbers.

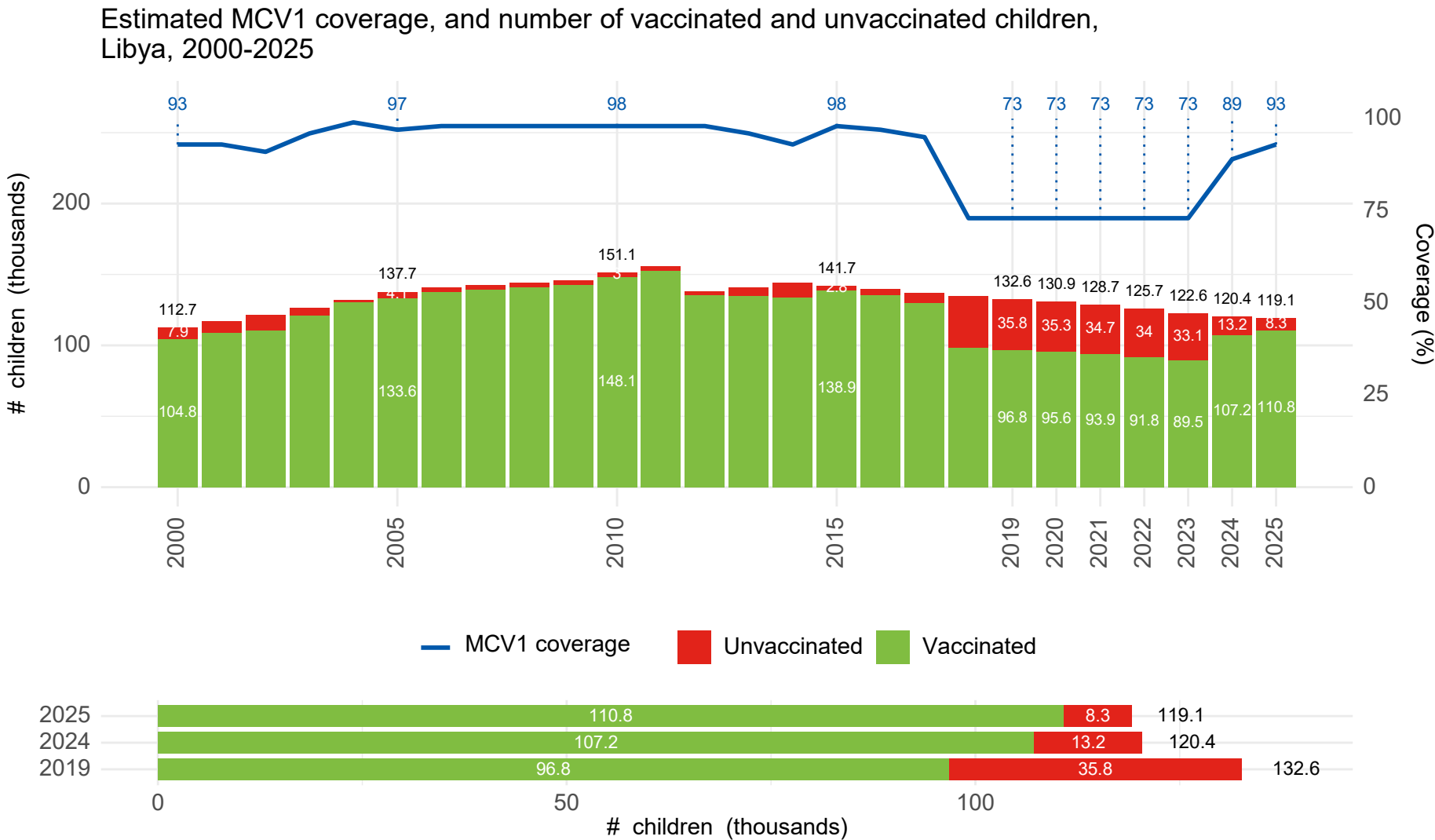
In 2025, Libya ranked number 6 out of 20 countries for lowest MCV1 coverage (based on tied ranks).

Libya was not in the top 10 countries with the most unvaccinated children.

Note: Large cohort countries may have high numbers of unvaccinated children despite high vaccine coverage. It is important to consider both coverage and absolute numbers of unvaccinated children to ensure vulnerable countries with small birth cohorts are not overlooked.

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: Bars are ranked by ascending coverage. Numbers in bubbles display top 10 rank based on absolute number of unvaccinated children.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision

MCV1 coverage in 2025 (93%) was higher than in 2019 (73%).

The number of children vaccinated with MCV1 increased 14% compared to in 2019.

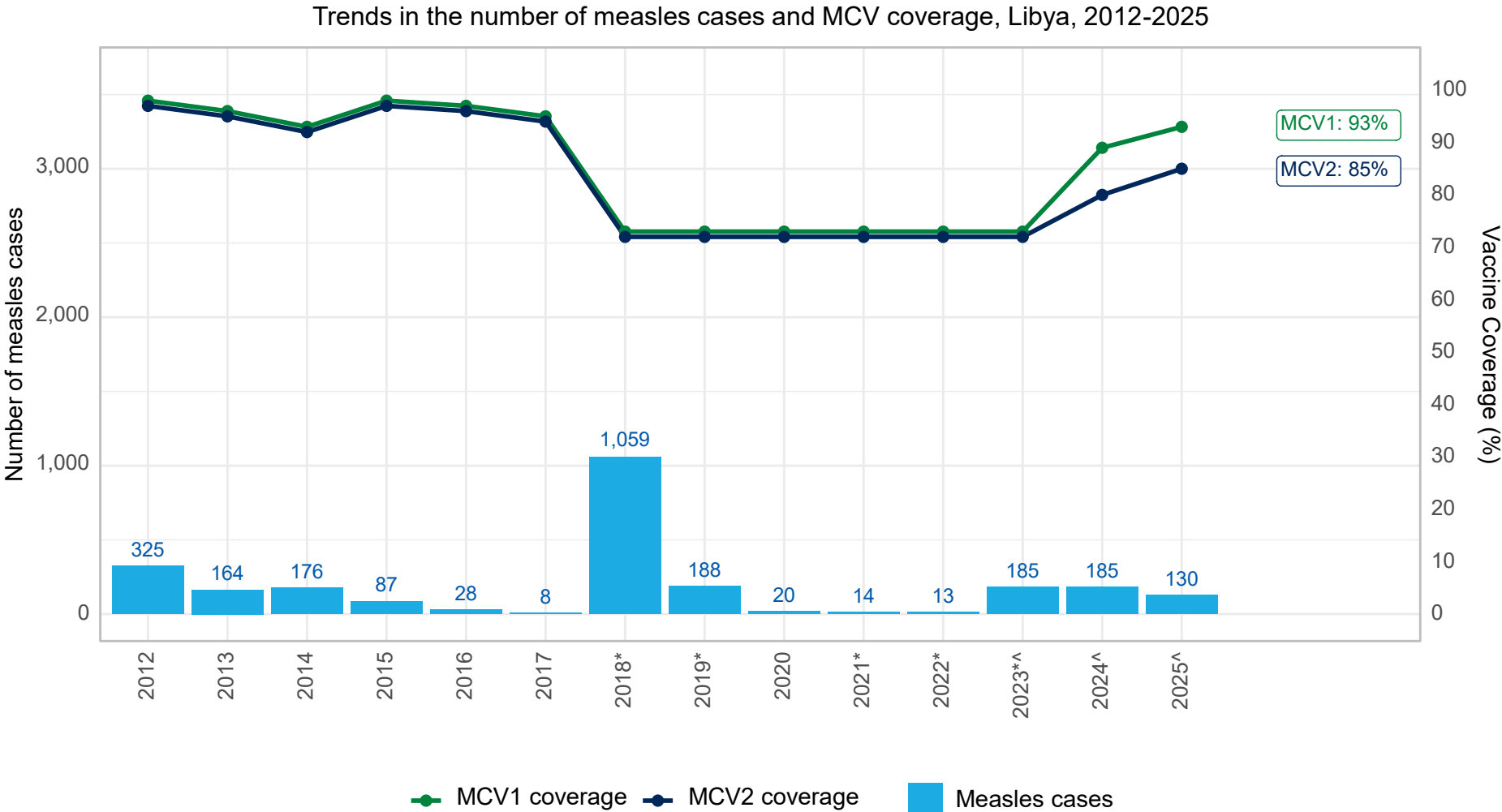
The number of surviving infants decreased approximately 10% compared to in 2019.

In 2025, more children were vaccinated than in 2019.

In 2025, there were fewer surviving infants (target population) than in 2019.

For vaccine coverage to increase, the number of children vaccinated needs to either increase or decline at a slower rate than the decline in surviving infant target population.

In 2025, Libya saw a decrease in measles cases compared with 2024, while MCV1 coverage was 93% and MCV2 coverage was 85%.



In 2025, there was a total of 130 confirmed measles cases in Libya. In the same year, MCV1 coverage was 93% and MCV2 coverage was 85%.

The number of cases in 2025 was 30% lower than in 2024 (n=185).

The highest number of measles cases was reported in 2018 (n=1,059). In this year, MCV1 coverage was 73%.

Libya reported measles vaccine stockouts in 2018, 2019, 2021, 2022, and 2023.

There were measles-containing vaccine supplementary immunization activities/campaigns in 2023, 2024, 2024, and 2025.

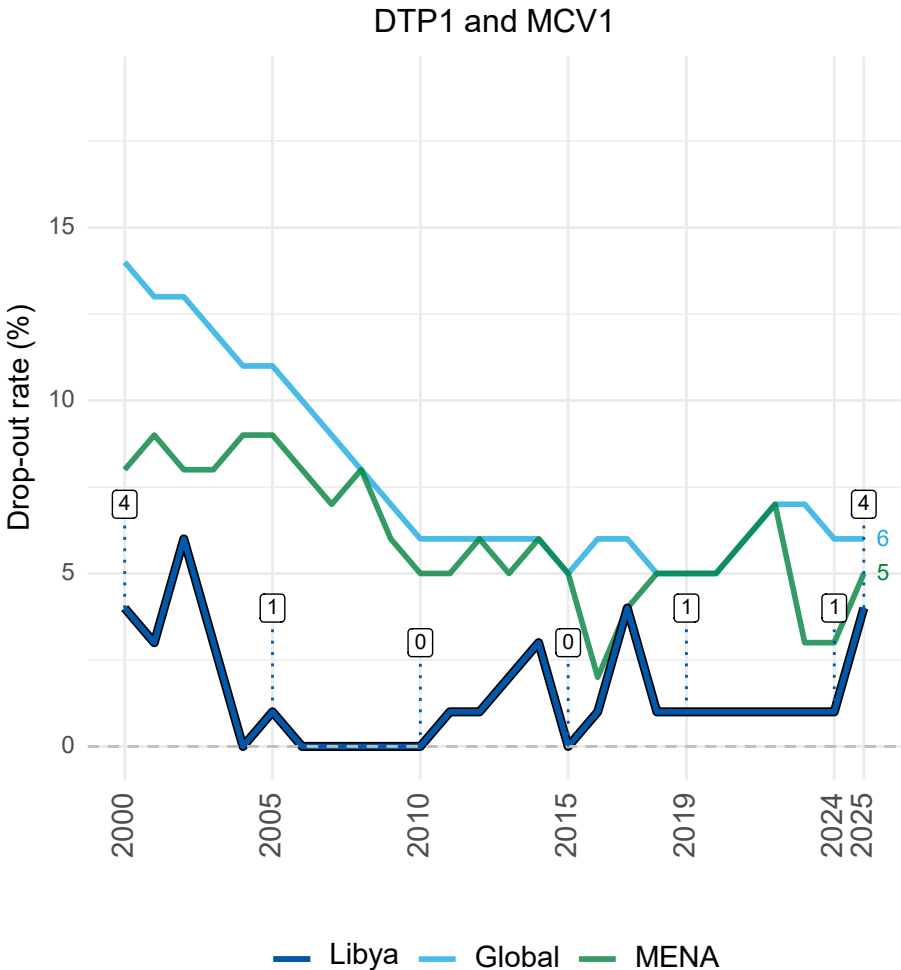
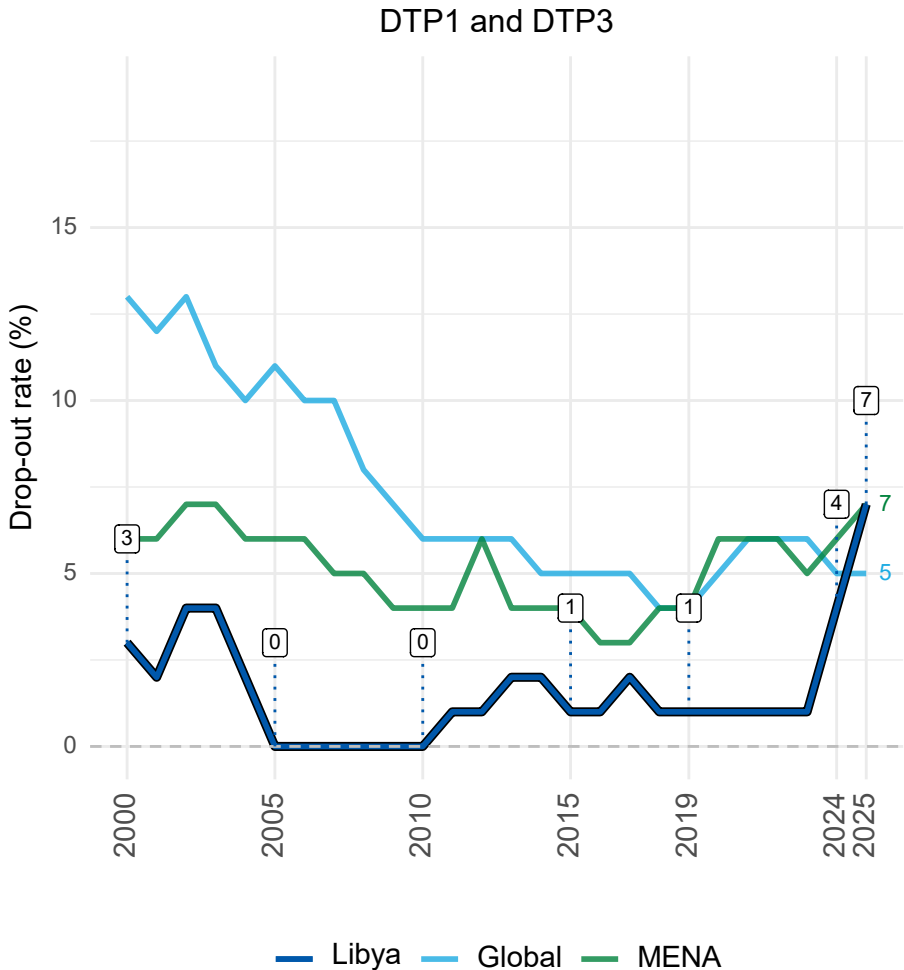
Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision; Reported measles and rubella cases and incidence rates by WHO Member States, as of 12 June 2026. Provisional data based on monthly data reported to WHO (Geneva) as of 12 June 2026.

Note: Asterisks (*) indicate years with measles vaccine stockouts and carets (^) indicates years with measles vaccination campaigns (national or subnational).

Childhood immunization: Additional charts

In 2025, DTP1-DTP3 drop-out was moderate (7%) and DTP1-MCV1 drop-out was low (4%) in Libya, indicating moderate ability to deliver the primary series early on, but good ability to provide the full course of vaccines in infancy.

Zero-dose children are those who did not receive DTP1.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Drop-out classification: <5% = low, 5-10% = medium, >10% = high

Drop-out rates show the percentage of children who received DTP1, but not DTP3/MCV1. Low drop-out rates indicate high retention of children in immunization programmes.

This chart shows trends in drop-out rates between DTP1 and DTP3, and DTP1 and MCV1.

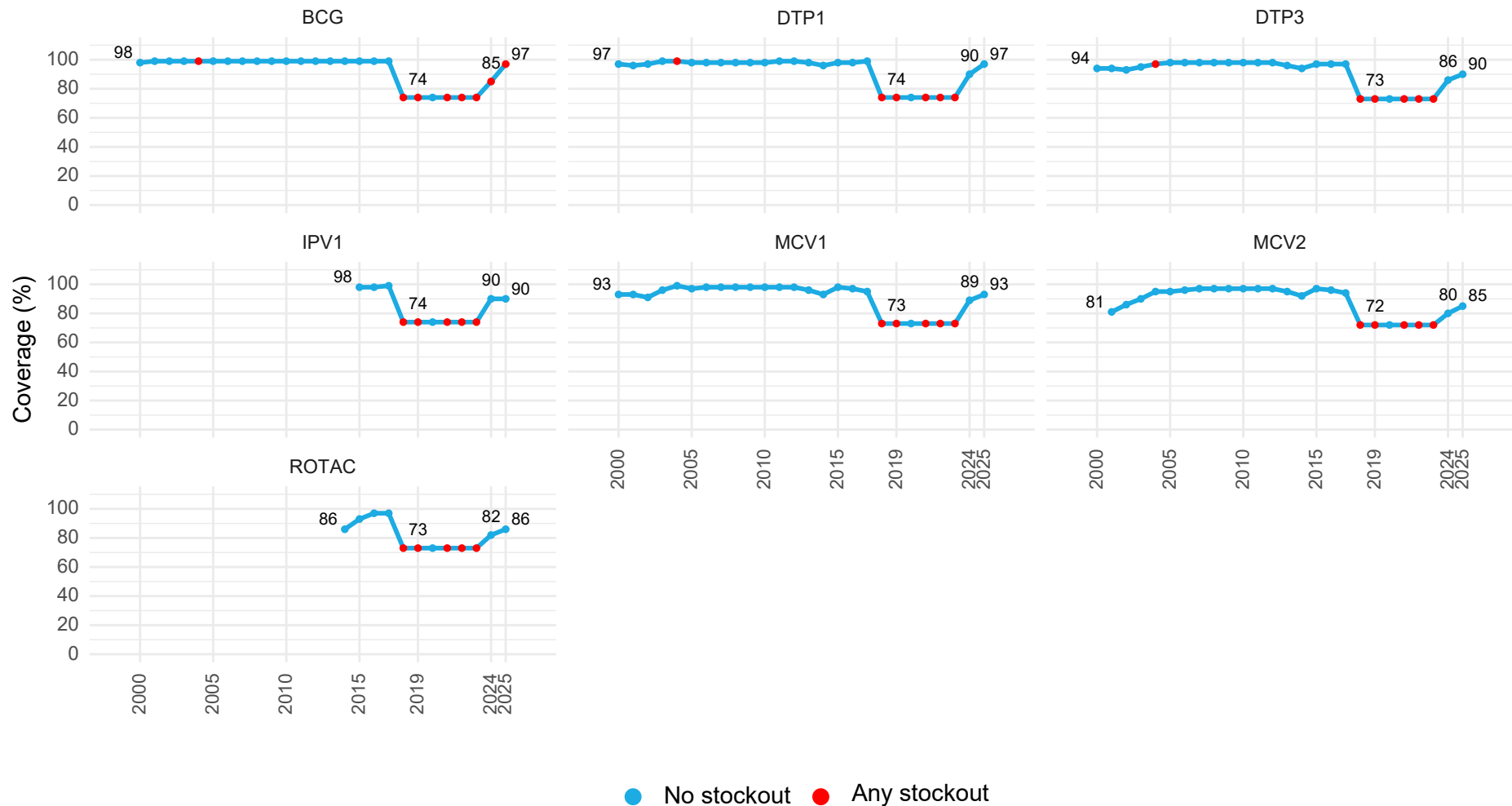
In 2025, 7% of children who received DTP1 did not receive DTP3 (left), and 4% of children who received DTP1 did not receive MCV1 (right).

The medium DTP drop-out rate implies moderate ability to provide a complete series of vaccines early in life. The low DTP-MCV drop-out rate implies good retention in immunization programmes and ability to provide a full course of vaccines in infancy (up to one year).

In 2025, Libya DTP drop-out was higher than the global rate, while DTP-MCV drop-out was lower than the global rate.

In 2025, Libya had its lowest coverage in MCV2 (85%), while most other routine vaccines clustered around 86-97%; 7 antigens increased since 2019, and 6 antigens increased since 2024.

Coverage of recommended childhood vaccines, Libya, 2000-2025



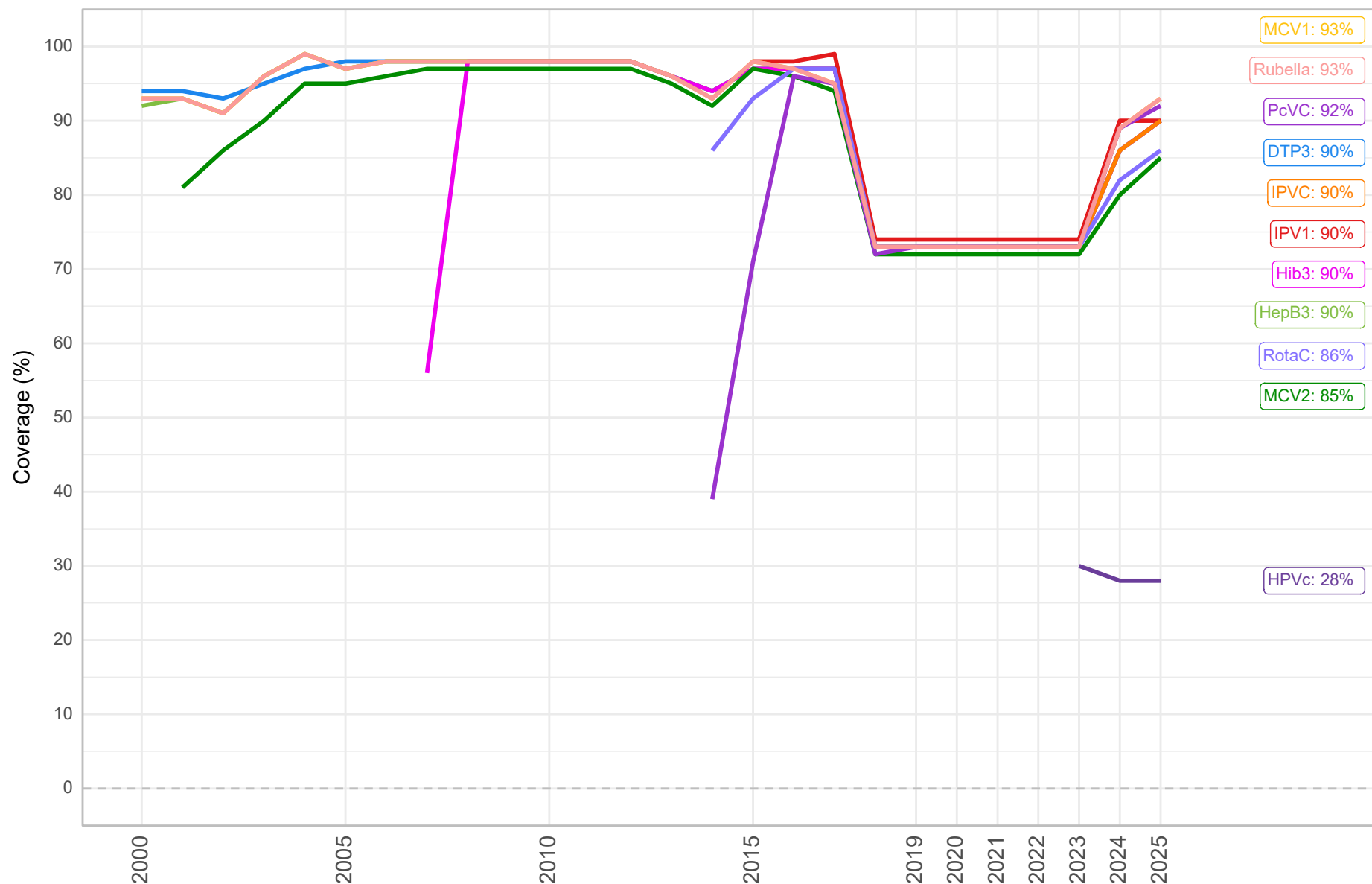
This chart shows trends in coverage of selected core routine vaccines recommended in childhood.

In 2025, MCV2 had the lowest coverage (85%), followed by ROTAC (86%).

Compared to 2019, coverage of 7 vaccines increased (BCG, DTP1, DTP3, IPV1, MCV1, MCV2 and ROTAC).

Compared to 2024, coverage of 6 vaccines increased (BCG, DTP1, DTP3, MCV1, MCV2 and ROTAC) and one vaccine remained constant (IPV1).

Vaccine coverage (%), Libya, 2000-2025



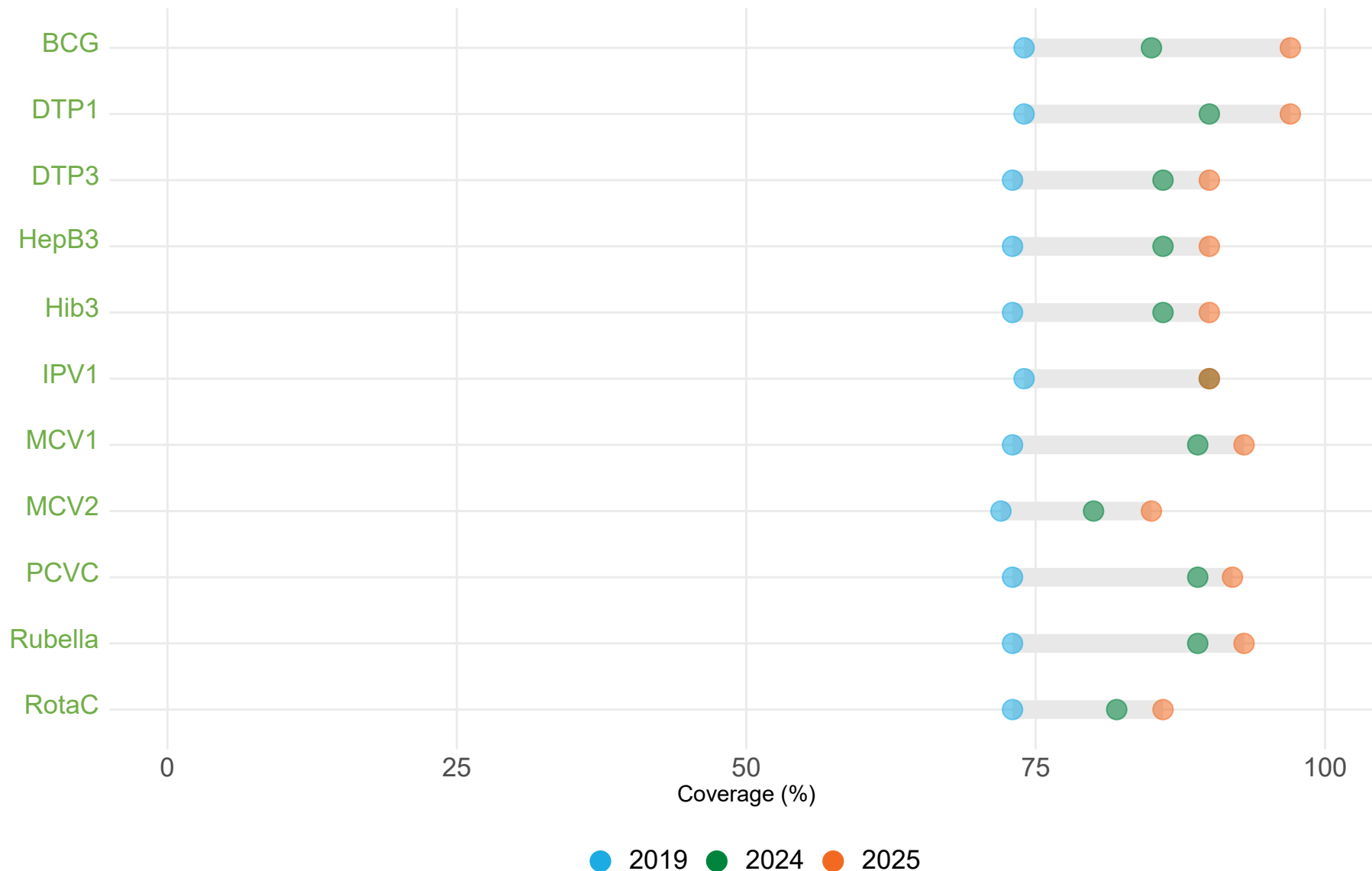
This chart shows trends in coverage of 10 vaccines (complete series).

In 2025, HPVc had the lowest coverage of all vaccines (28%), followed by MCV2 (85%).

Coverage of 8 vaccines increased (DTP3, HEPB3, HIB3, IPV1, MCV1, MCV2, ROTAC and RUBELLA) compared to respective coverage in 2019.

Coverage of 8 vaccines increased (DTP3, HEPB3, HIB3, IPVC, MCV1, MCV2, ROTAC and RUBELLA) and 2 vaccines were the same (HPVc and IPV1) compared to respective coverage in 2024.

Vaccine coverage (%), Libya, 2019-2025



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
 Note: The grey bar spans vaccine coverage across all years 2019-2025 and the dots represent coverage in specific years.
 Coverage is shown for vaccines with data all years 2019-2025.
 Vaccine names are coloured based on if coverage is lower (red), the same as (blue) or higher (green) than in 2019

This chart shows the range of coverage across all years 2019 to 2025 (grey bars), and coverage in specific years (dots), by vaccine. The chart can be used for assessing recovery to pre-pandemic levels.

DTP1 coverage increased between 2019 (74%) and 2024 (90%). DTP1 coverage increased in 2025 (97%) compared to 2024, and was higher than in 2019. In 2019-2025, DTP1 coverage was at it's lowest level in 2019, 2020, 2021, 2022, and 2023 (74%).

In 2024, 0 vaccines had lower coverage than in 2019.

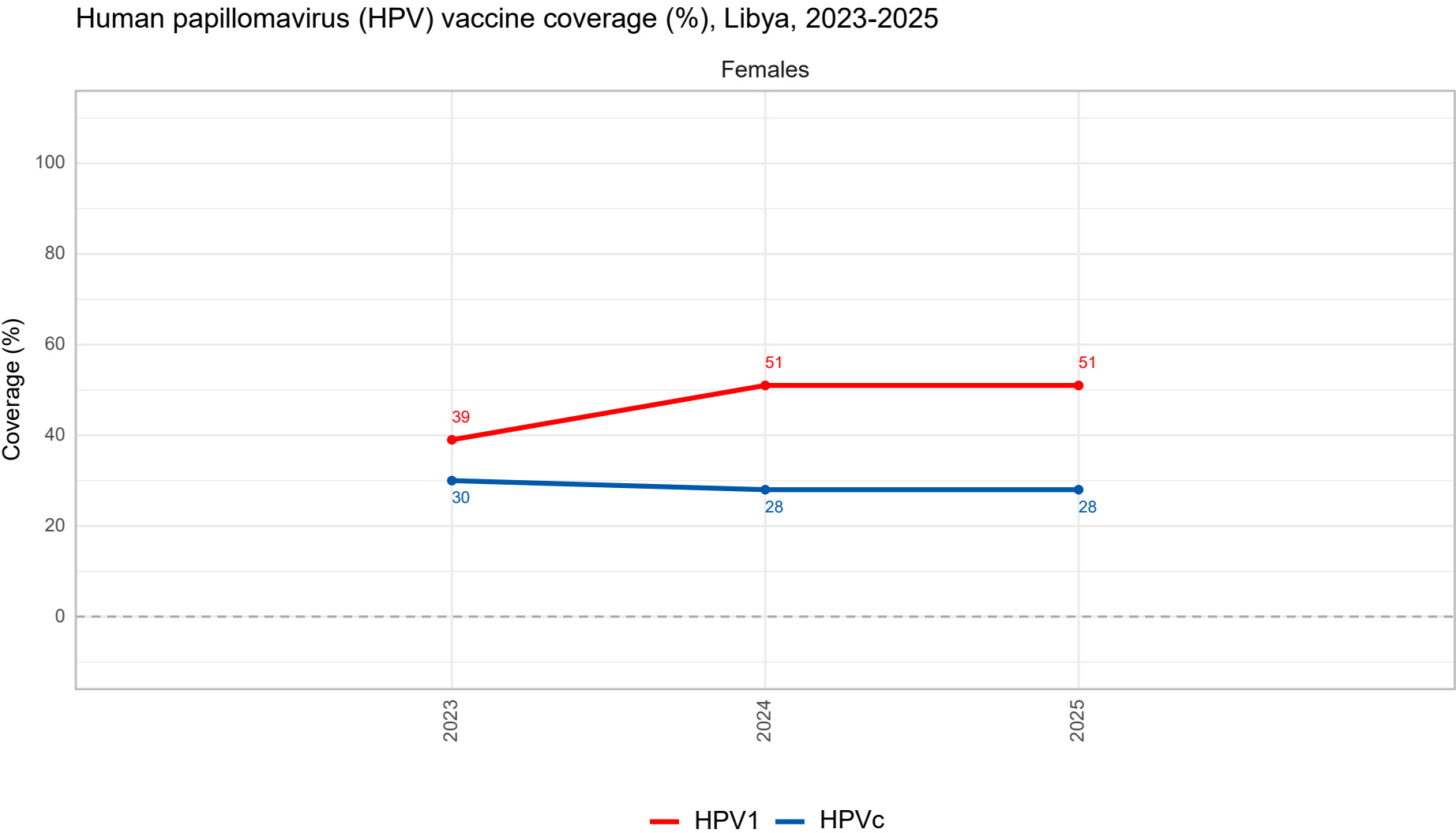
In 2025, 0 vaccines had lower coverage than in 2019.

In 2025, 0 vaccines had lower coverage than in 2024.

HPV vaccination

Methods: • [Bruni et al. 2021, HPV vaccination introduction worldwide and WHO and UNICEF estimates of national HPV immunization coverage 2010–2019 \(supplementary materials\).](#)

In 2025, HPV last dose coverage among girls remained at 28%.



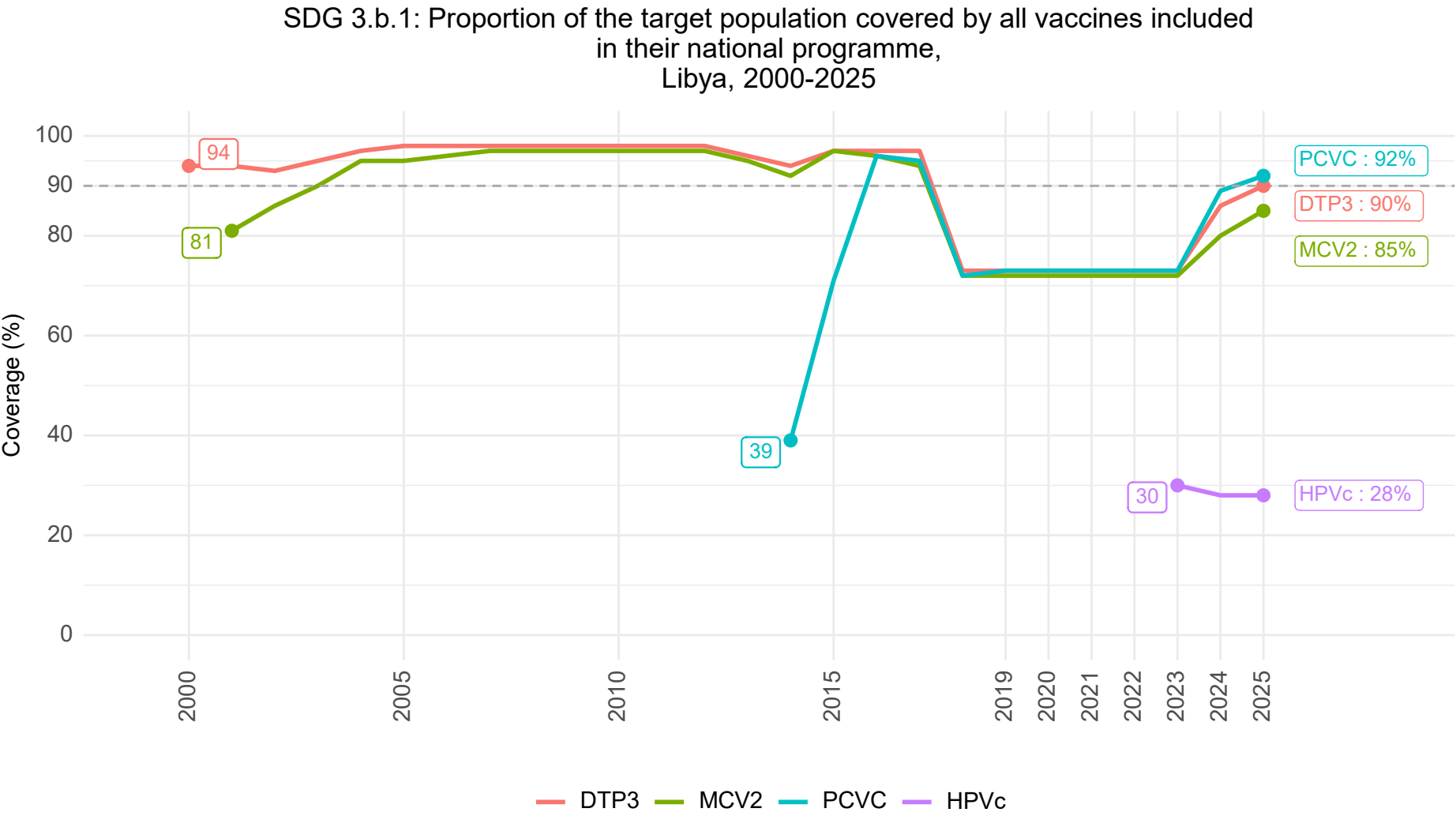
The first year of HPV programme coverage estimates in Libya was 2023.

In 2025, first dose (HPV1) programme coverage among girls was 51%. In 2025, last dose (HPVc) programme coverage among girls was 28%.

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision.
For some countries, if HPV vaccine is in the schedule, but the country did not report data in a given year, HPV programme coverage estimates are not produced.

SDG 3.b.1

In 2025, Libya met the 90% SDG coverage target for DTP3 and PCVC, but not for the remaining vaccines.



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision
Note: The four vaccination coverage indicators contribute to SDG indicator 3.b.1 are: DTP3, MCV2, PCVC and HPVc
The Immunization Agenda 2030 (IA2030) global target is 90% coverage of all four antigens by 2030.

Four vaccination coverage indicators contribute to Sustainable Development Goal 3, indicator b.1: DTP3, PCV3, MCV2 and HPV.

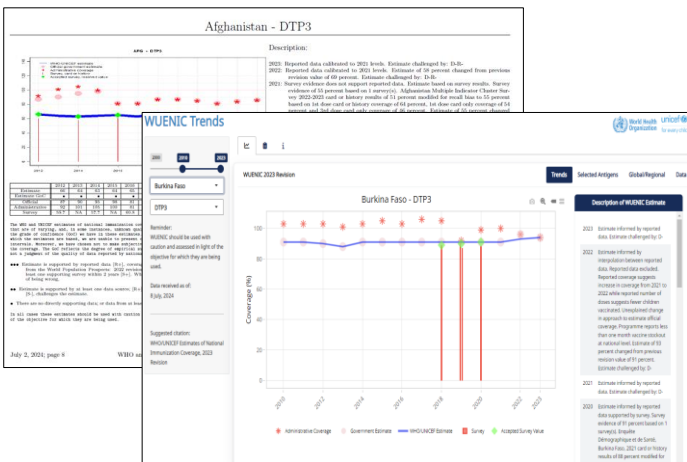
The IA2030 global target is 90% coverage of all four antigens by 2030.

Libya has all 4 of the SDG vaccines.

In 2025, Libya had achieved at least 90% coverage of 2 out of the 4 vaccines.

Additional resources

WUENIC country profiles (PDF and interactive versions)

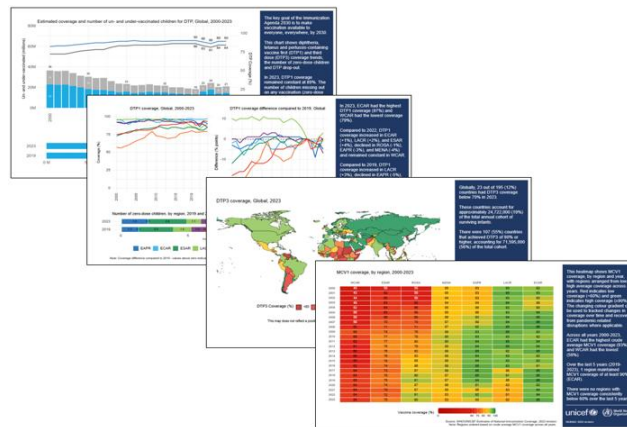


Datasets: WUENIC, HPV, survey database

	A	B	C	D	E	F	G	H	I	J
	unicef_regioiso3c	country	vaccine	year	target_grp	coverage	vaccinated	unvaccinated	target	
1	ROSA	AFG	Afghanistan bcg	1982	births	10	57,000	514,000	571,000	
2	ROSA	AFG	Afghanistan bcg	1983	births	10	56,000	503,000	559,000	
3	ROSA	AFG	Afghanistan bcg	1984	births	11	62,000	501,000	563,000	
4	ROSA	AFG	Afghanistan bcg	1985	births	17	100,000	490,000	591,000	
5	ROSA	AFG	Afghanistan bcg	1986	births	18	107,000	489,000	596,000	
6	ROSA	AFG	Afghanistan bcg	1987	births	27	161,000	434,000	595,000	
7	ROSA	AFG	Afghanistan bcg	1988	births	40	238,000	358,000	596,000	
8	ROSA	AFG	Afghanistan bcg	1989	births	38	233,000	380,000	614,000	
9	ROSA	AFG	Afghanistan bcg	1990	births	30	191,000	446,000	637,000	
10	ROSA	AFG	Afghanistan bcg	1991	births	21	134,000	505,000	640,000	
11	ROSA	AFG	Afghanistan bcg	1992	births	19	127,000	541,000	668,000	
12	ROSA	AFG	Afghanistan bcg	1993	births	17			760,000	
13	ROSA	AFG	Afghanistan bcg	1994	births	15			852,000	
14	ROSA	AFG	Afghanistan bcg	1995	births				899,000	
15	ROSA	AFG	Afghanistan bcg	1996	births				932,000	
16	ROSA	AFG	Afghanistan bcg	1997	births				962,000	
17	ROSA	AFG	Afghanistan bcg	1998	births				986,000	
18	ROSA	AFG	Afghanistan bcg	1999	births				1,013,000	
19	ROSA	AFG	Afghanistan bcg	2000	births	30			1,037,000	
20	ROSA	AFG	Afghanistan bcg	2001	births	43	453,000	374,000	1,007,000	
21	ROSA	AFG	Afghanistan bcg	2002	births	46	467,000	548,000	1,015,000	

Country and region-specific slides:

UNICEF, WHO, World Bank, Gavi and African Union regions



Additional Resources

Additional immunization data resources can be found at:

<https://data.unicef.org/resources/immunization/>

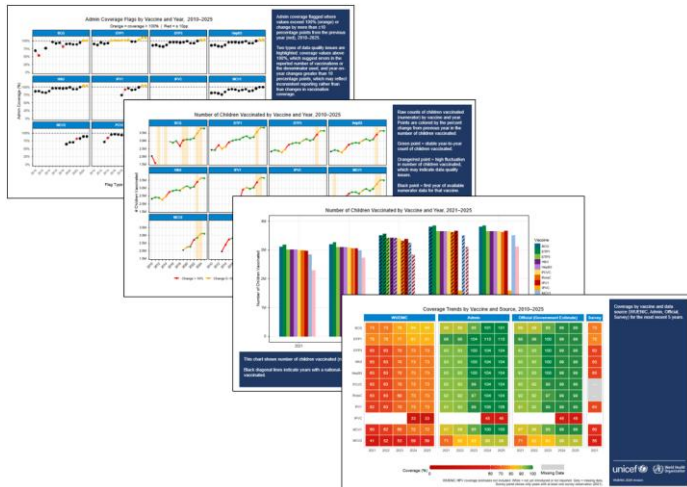
Interactive immunization regional snapshots:

UNICEF, WHO, World Bank, Gavi and African Union regions



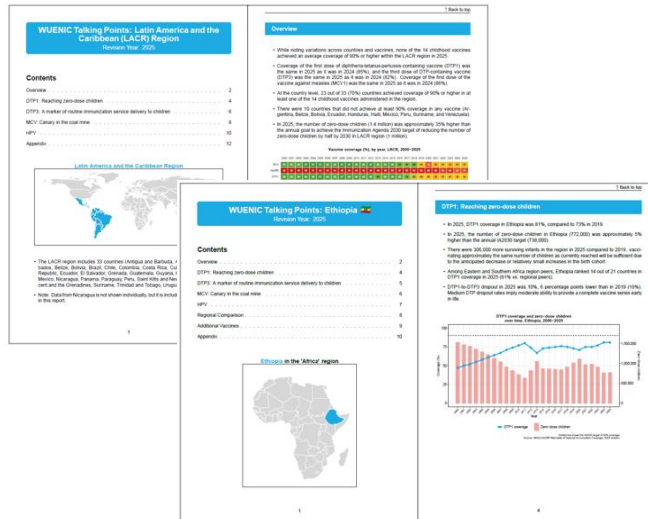
Country data quality reports

(NEW 2026)



Country and region-specific high-level talking points

(NEW 2026)



Interactive WUENIC country profiles can be found at:

<https://worldhealthorg.shinyapps.io/wuenic-trends/>

Short feedback questionnaire

(5 minutes)

We are seeking your feedback on the global groupings (GAVI, African Union, World Bank Income, WHO and UNICEF) and country-level PowerPoint slides developed for the release of global immunization estimates. Your input will help us understand their usefulness and identify areas for improvement.

Please take a few moments to complete this short survey and have your voice heard:

<https://forms.office.com/e/Qv1HXxxNZQ>

