



# Marshall Islands

WUENIC 2025 revision,  
Published 15 July 2026



# 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 remained constant at 98% between 2024 and 2025.
- DTP3 coverage remained constant at 85% between 2024 and 2025.
- There were there were approximately the same number of zero-dose children in 2025. This leaves <100 children without vaccination, vulnerable to vaccine-preventable diseases and a further <100 with incomplete protection.
- Marshall Islands accounted for <0.1% of zero-dose children in East Asia and the Pacific (EAPR) and <0.1% of zero-dose children globally.
- MCV1 coverage remained constant at 88% between 2024 and 2025. There were <100 children who missed out on the first measles vaccination.
- MCV2 coverage remained constant at 61% between 2024 and 2025.
- Last dose coverage of HPV vaccination (HPVc) among girls remained constant at 50% in 2025.

# Vaccination schedule, 2025

| Level    | Vaccine               | Dose number and age administered |           |           |           |
|----------|-----------------------|----------------------------------|-----------|-----------|-----------|
|          |                       | 1                                | 2         | 3         | 4         |
| National | BCG                   | Birth                            |           |           |           |
| National | DTAPHEPBIPV           | 2 months                         | 4 months  | 6 months  |           |
| National | DTAPHEPBIPV (booster) |                                  |           |           | 12 months |
| National | DTAPHIBIPV            | 2 months                         | 4 months  | 12 months |           |
| National | HEPB (pediatric)      | Birth                            | 2 months  | 6 months  |           |
| National | HIB                   | 2 months                         | 4 months  | 12 months |           |
| National | HPV (females)         | 9-14 years                       |           |           |           |
| National | IPV                   | 2 months                         | 4 months  | 6 months  |           |
| National | MMR                   | 12 months                        | 15 months |           |           |
| National | PCV                   | 2 months                         | 4 months  | 6 months  | 12 months |
| National | Rotavirus             | 2 months                         | 4 months  | 6 months  |           |

This table shows the 2025 national immunization schedule for routine services in Marshall Islands, 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 | Partial introduction |
|---------------------------------------------------------|-----------------------|----------------------|
| HPV (Human papillomavirus) vaccine                      | 2009                  |                      |
| HepB birth dose                                         | 1998                  |                      |
| Hepatitis B vaccine                                     | 1988                  | 1983                 |
| Hib (Haemophilus influenzae type B) vaccine             | 1998                  |                      |
| IPV (Inactivated polio vaccine)                         | 2010                  |                      |
| IPV (Inactivated polio vaccine) 2nd dose                | 2010                  |                      |
| Malaria vaccine                                         | Not introduced        |                      |
| Measles-containing vaccine 2nd dose                     | 1998                  |                      |
| Meningococcal meningitis vaccines (any strain)          | 2010                  |                      |
| Mumps vaccine                                           | 1998                  |                      |
| PCV (Pneumococcal conjugate vaccine)                    | 2009                  |                      |
| RSV (Respiratory syncytial virus) immunization strategy | Not introduced        |                      |
| Rotavirus vaccine                                       | 2009                  |                      |
| Rubella vaccine                                         | 1998                  |                      |
| Typhoid conjugate vaccine                               | Not introduced        |                      |

This table displays the year each vaccine was introduced in Marshall Islands. 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 | 2024          |
|---------------------|---------------|
| BCG                 | National (1m) |

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.

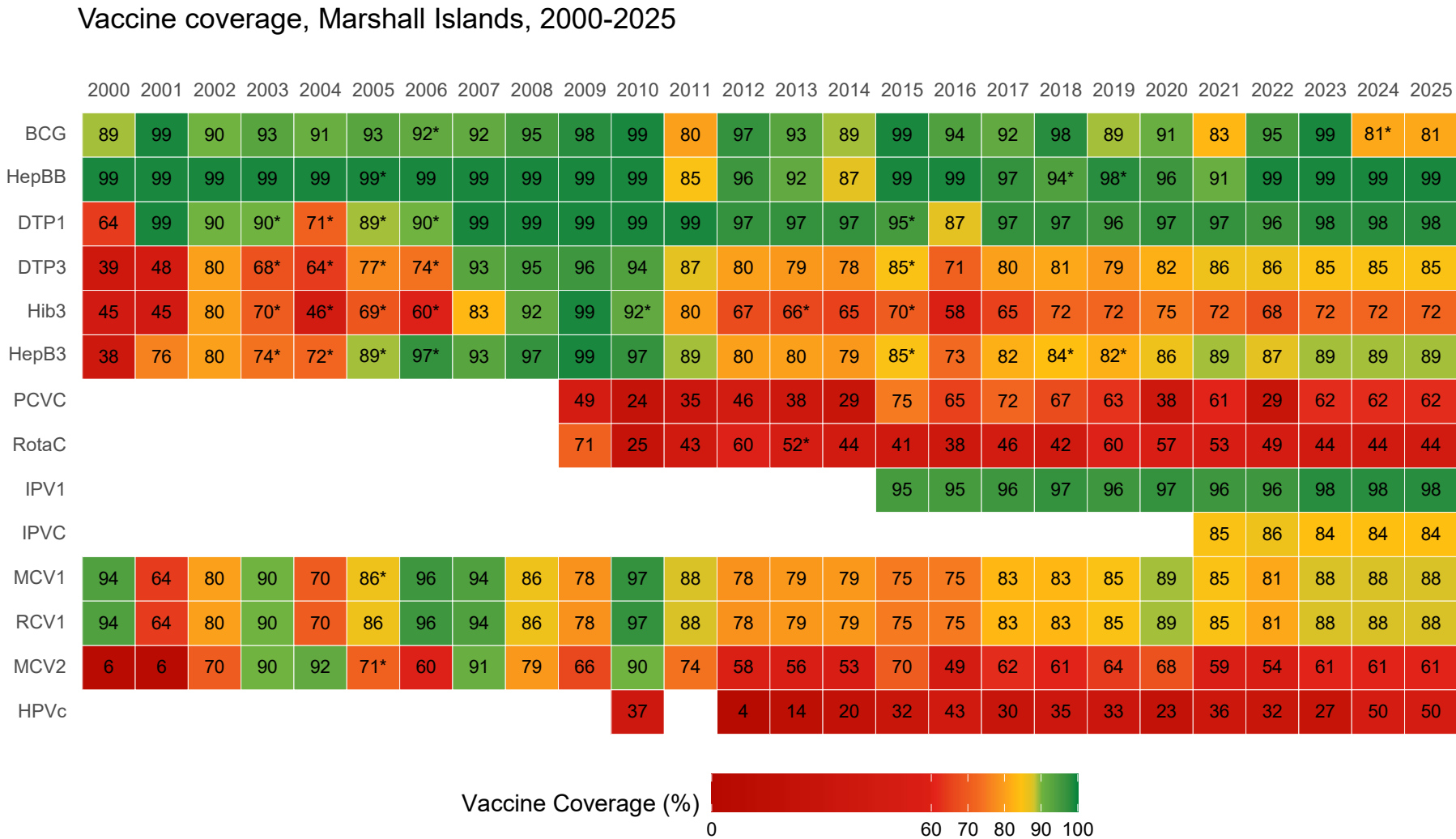
In 2025, coverage remained unchanged since 2024 for all antigens, with three achieving at least 90% coverage, indicating good reach of at least some antigens.

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

In 2025, 3 out of 14 (21%) vaccines in the schedule achieved coverage of 90% or more. Vaccine coverage ranged from 44% to 99%.

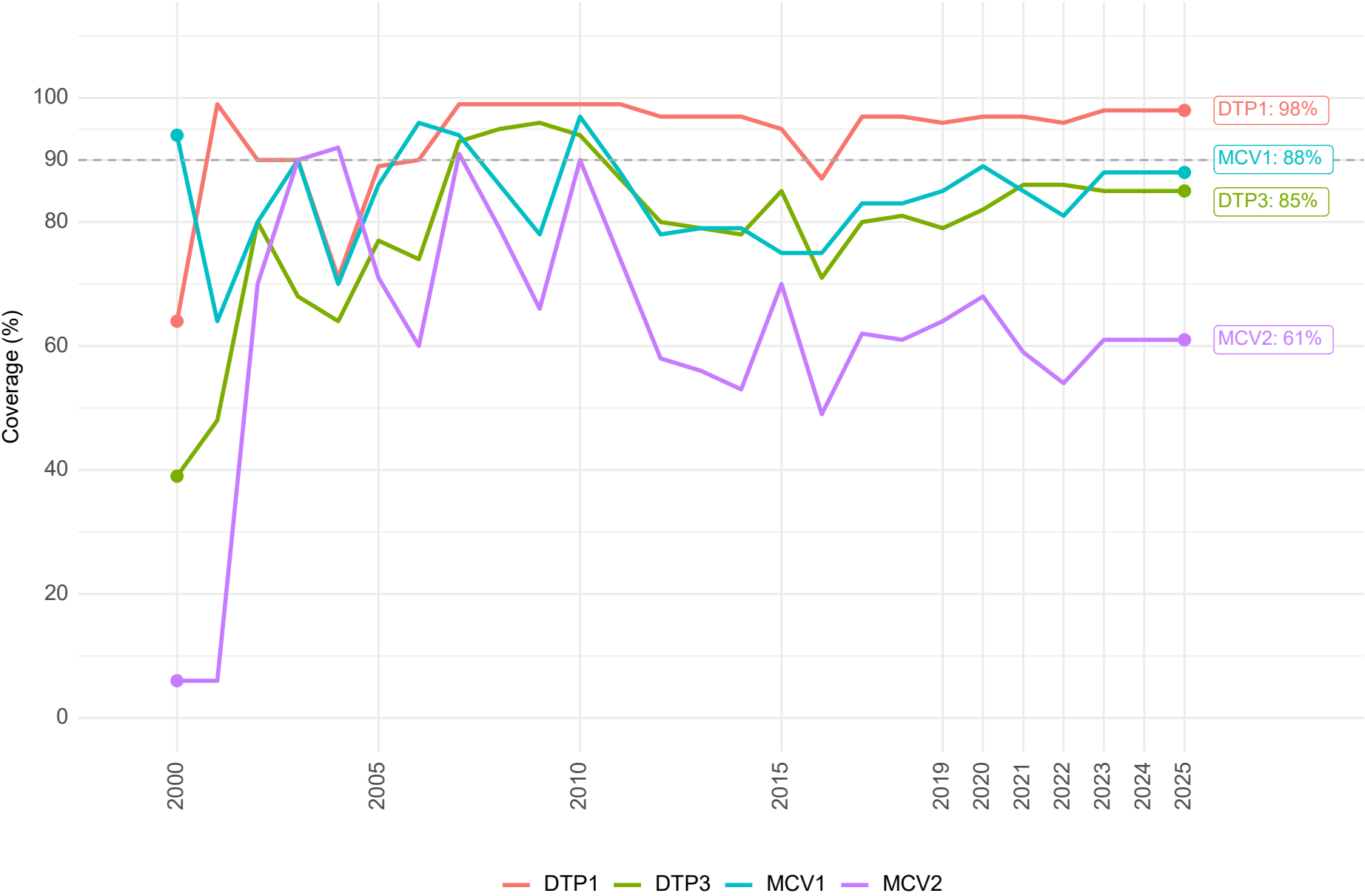
Since 2009, estimates have been made for 5 new vaccines. IPV1 is the newest vaccine reported (2021), which achieved 84% coverage in 2025.

In 2025, Marshall Islands did not report any stockouts of vaccines or supplies.



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.

Coverage of key childhood vaccines (%), Marshall Islands, 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 88%.

DTP3 coverage - a marker of how well countries are delivering immunization services to children - fell short of, but was close to the 90% target.

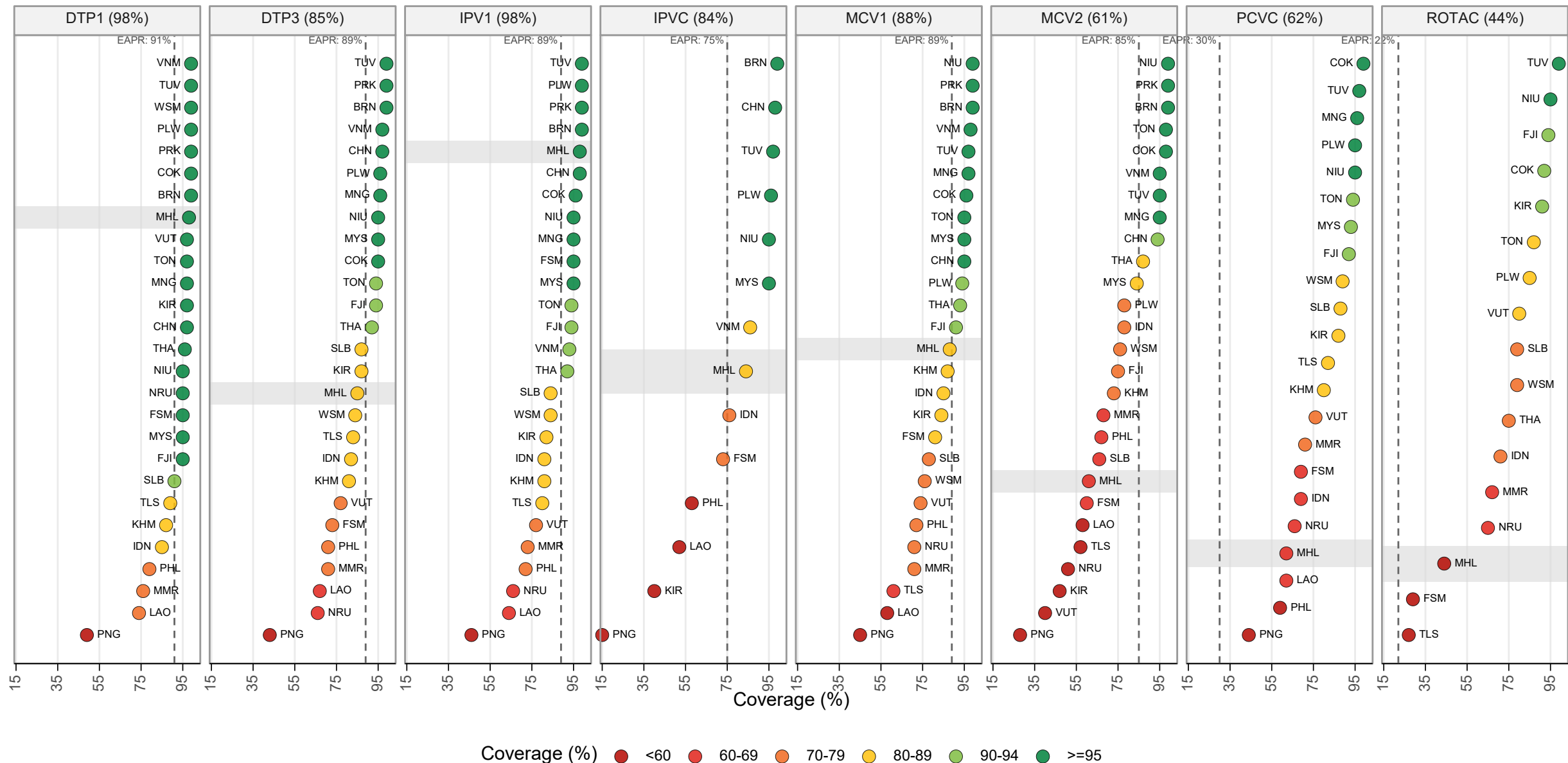
WHO recommends that countries achieve at least 95% coverage with both the first (MCV1) and second (MCV2) doses of measles-containing vaccine. MCV1 provides initial protection and MCV2 ensures long-term immunity and closes gaps in coverage.

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

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

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

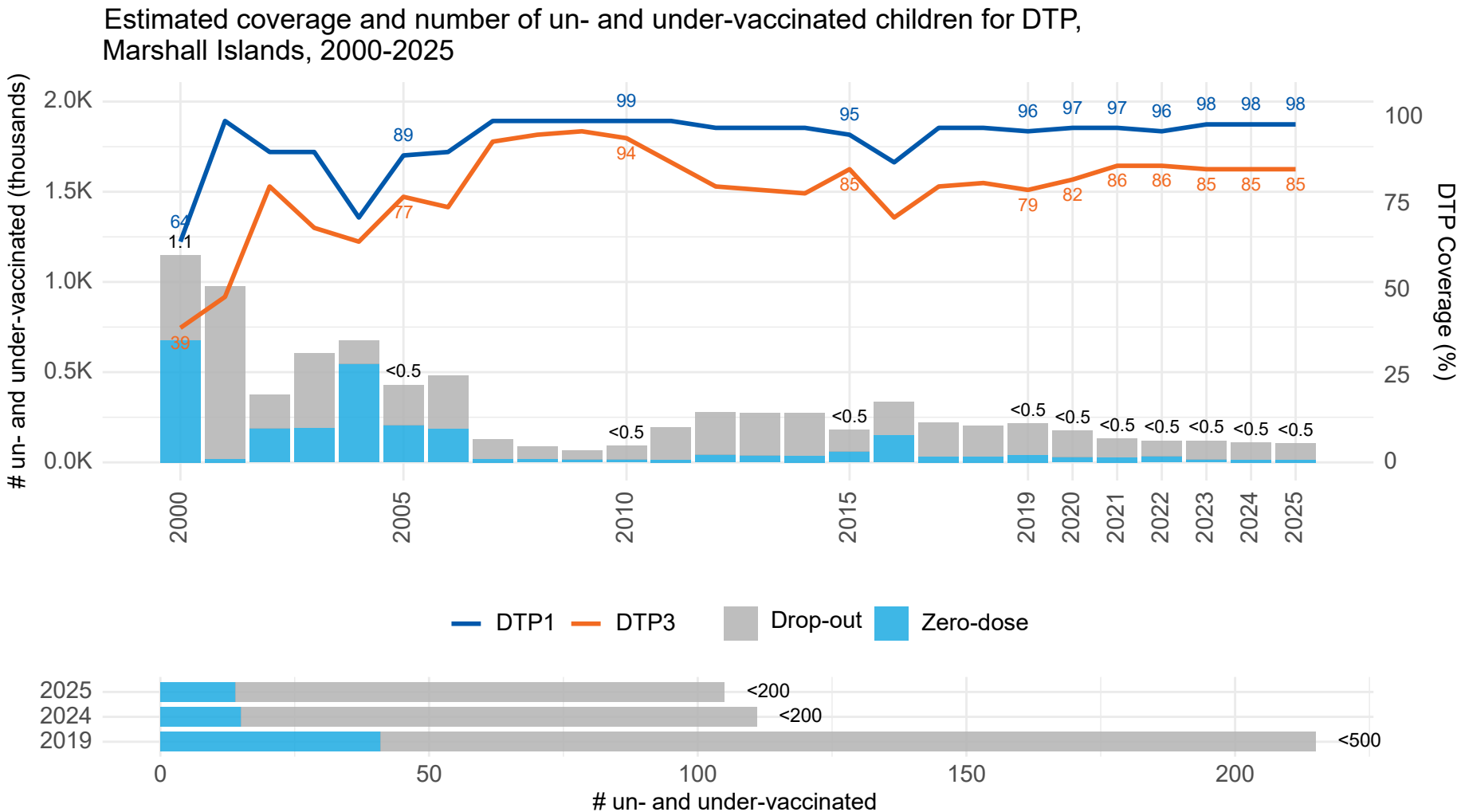
Vaccine coverage compared with other countries in the region, EAPR, 2025



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

DTP1

In 2025, DTP1 coverage was 98% and DTP3 was 85%, leaving <200 children un- or under-vaccinated, including <100 zero-dose and <100 with only partial protection.



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.

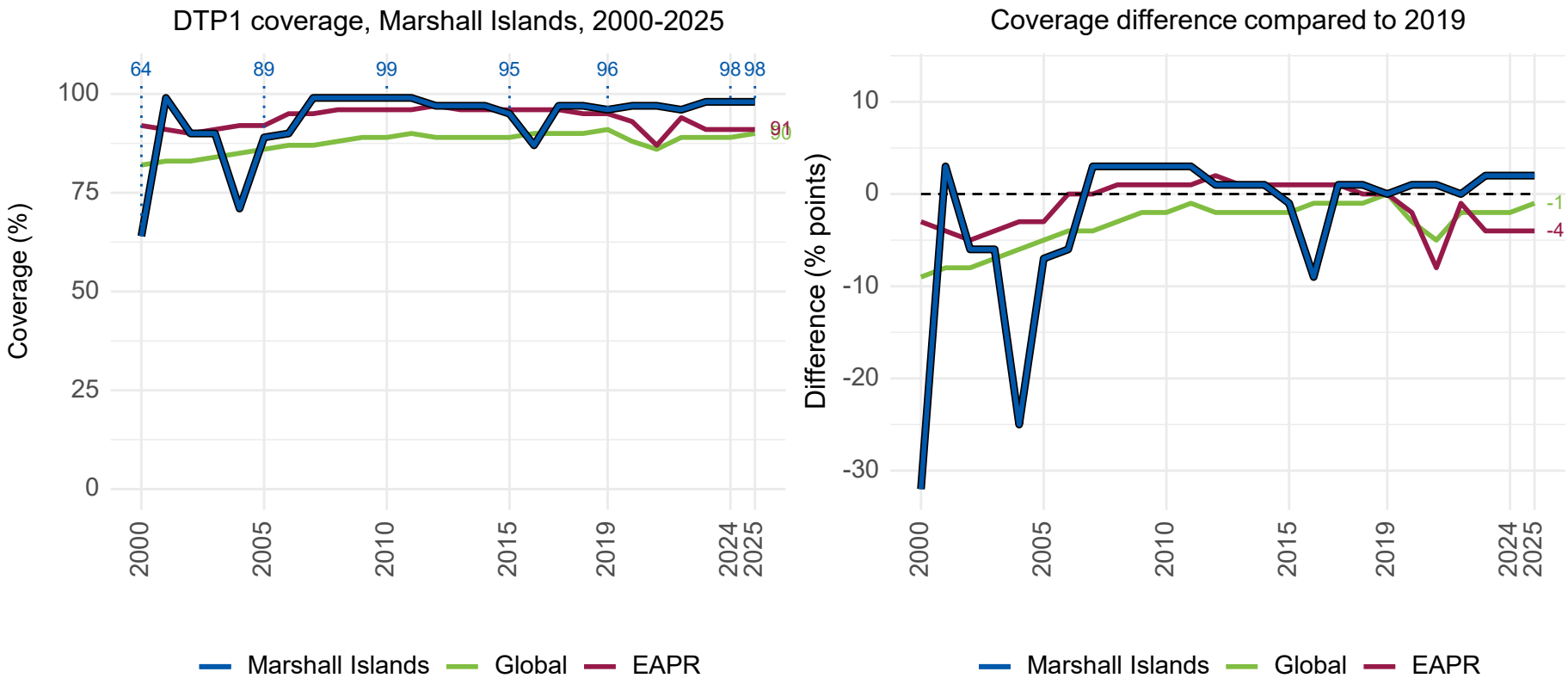
The key goal of the Immunization Agenda 2030 is to make vaccination available to everyone, everywhere, by 2030.

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 Marshall Islands.

In 2025, DTP1 coverage in Marshall Islands remained constant 98%. There were <100 children who missed out on any DTP vaccination (zero-dose children).

DTP3 coverage remained constant at 85% in 2025, leaving <200 children vulnerable to vaccine-preventable diseases.

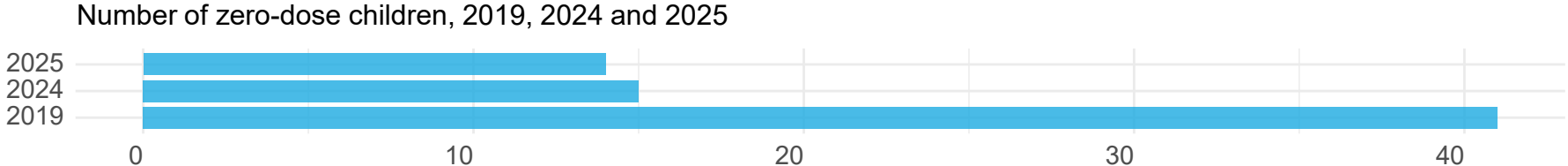
In 2025, Marshall Islands DTP1 coverage was 98% - this is 2 percentage points higher than in 2019 and higher than both the global and regional averages.



In 2025, DTP1 coverage in Marshall Islands (98%) was 8 percentage points higher than the global average (90%) and 7 percentage points higher than the average across all EAPR countries (91%).

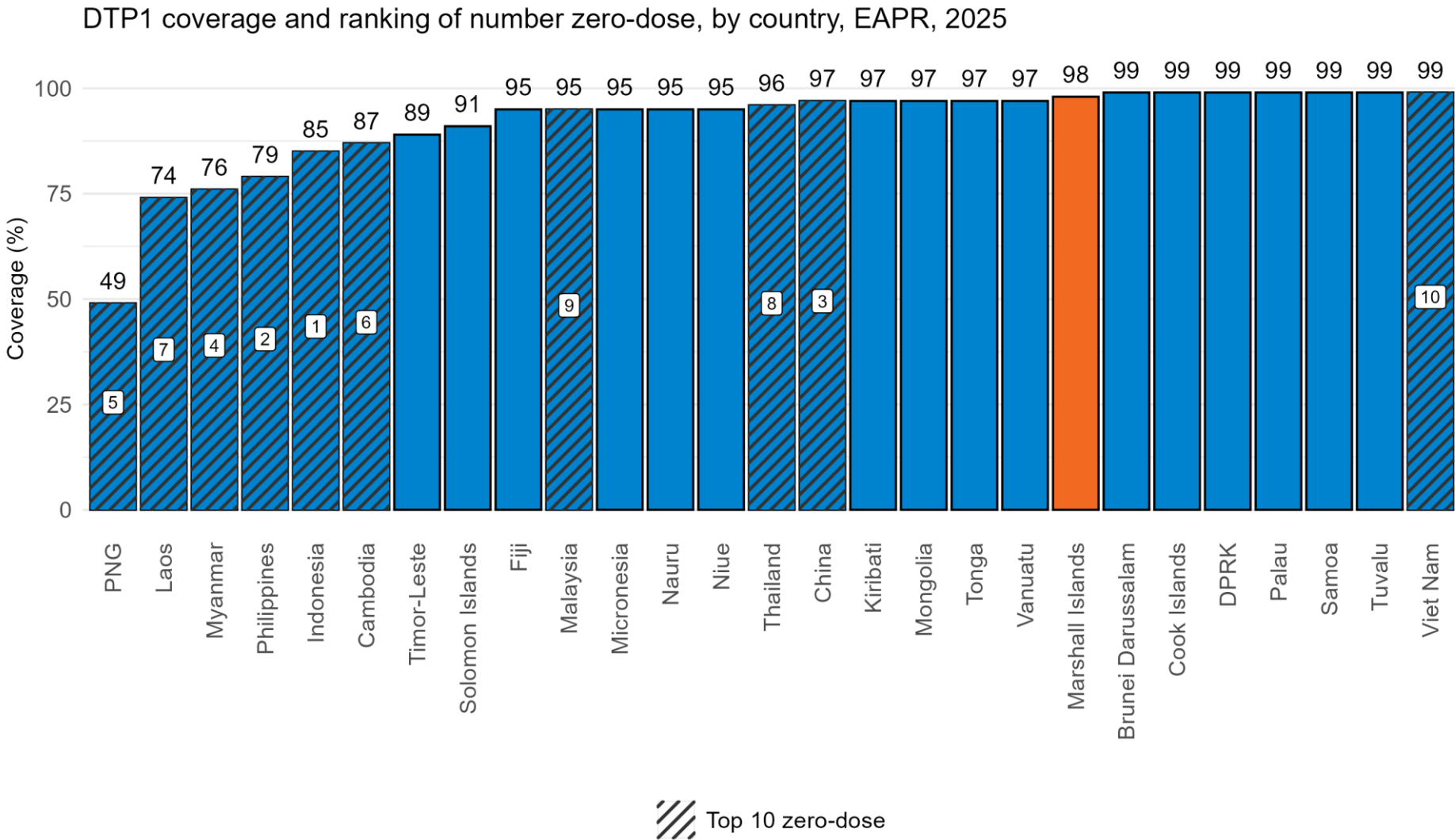
National DTP1 coverage was 2 percentage points higher than in 2019 (96%).

The number of zero-dose children remained approximately the same (<100) as 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, Marshall Islands had DTP1 coverage of 98% and was not among the top 10 countries with the highest number of zero-dose children in the region.



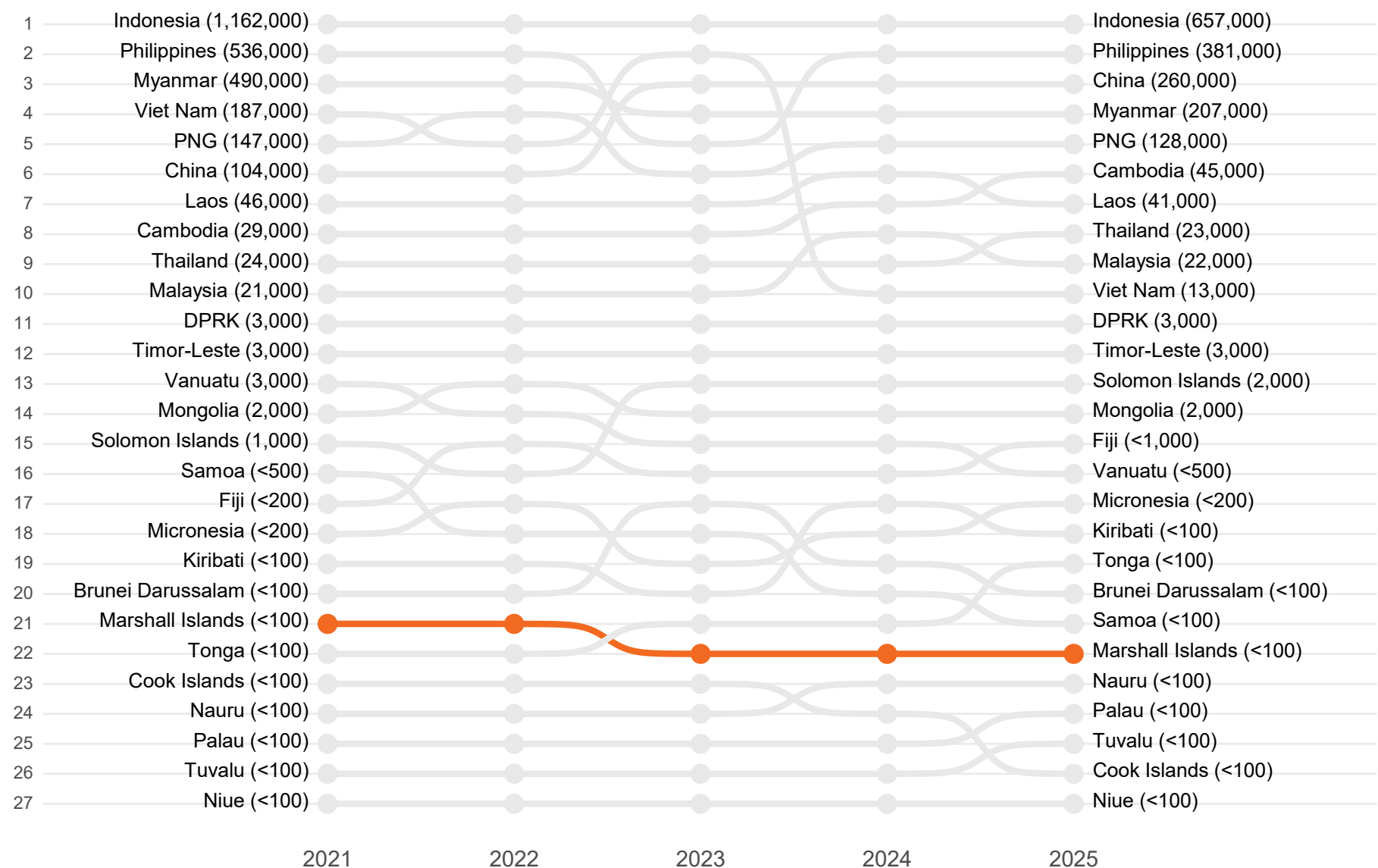
This chart shows DTP1 coverage in countries in EAPR from lowest to highest coverage, and the rank of the top 10 countries with the most zero-dose children, based on absolute numbers.

In 2025, Marshall Islands ranked number 20 out of 27 countries for lowest DTP1 coverage (based on tied ranks).

Marshall Islands 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.

Countries ranked by number of zero-dose children, EAPR, 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.

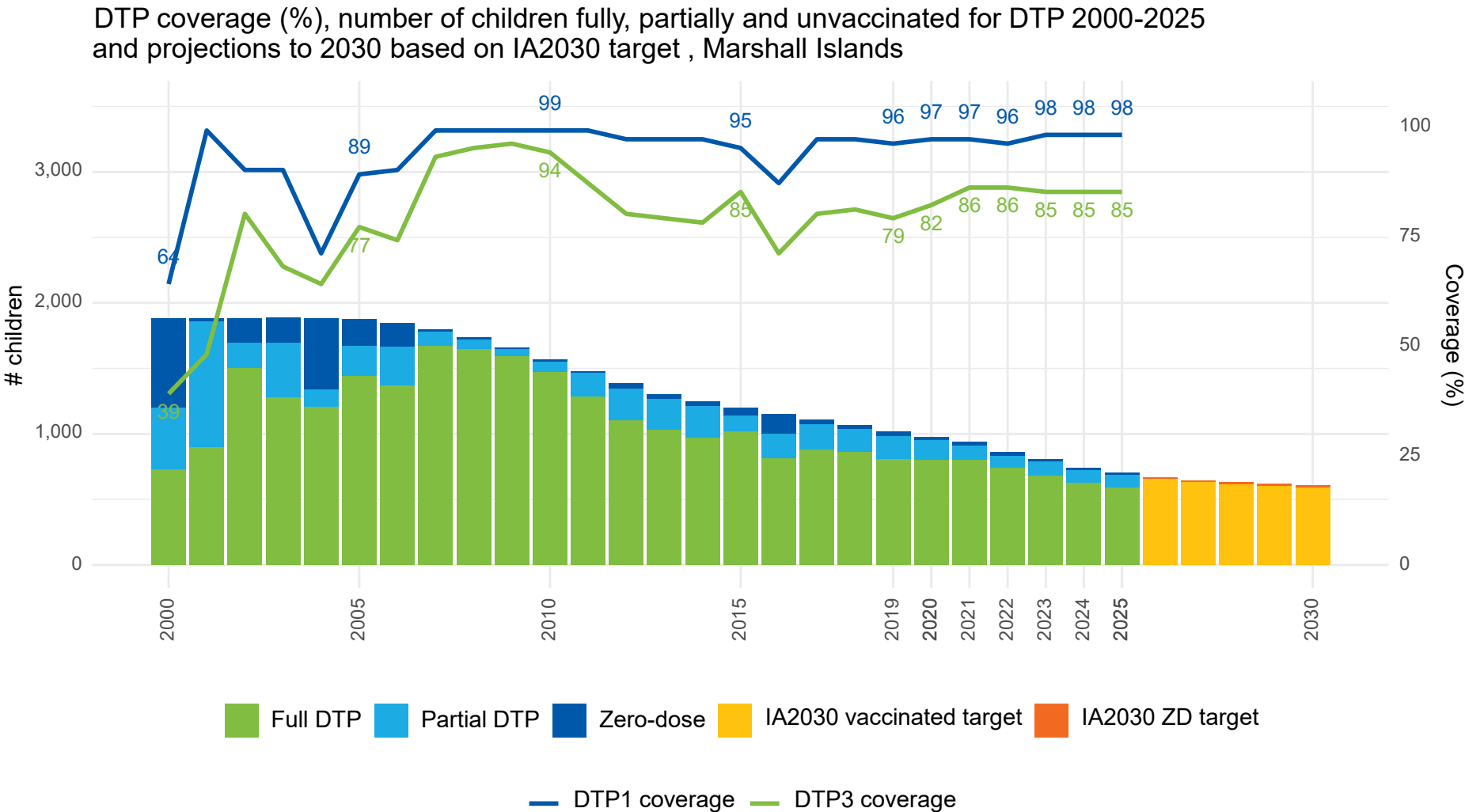
In 2021, Marshall Islands ranked number 21 out of 27 countries with <100 zero-dose children.

In 2025, Marshall Islands ranked number 22 out of 27 countries with <100 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.

Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision  
Note: Number in parentheses is the number of zero-dose children.

Marshall Islands 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.

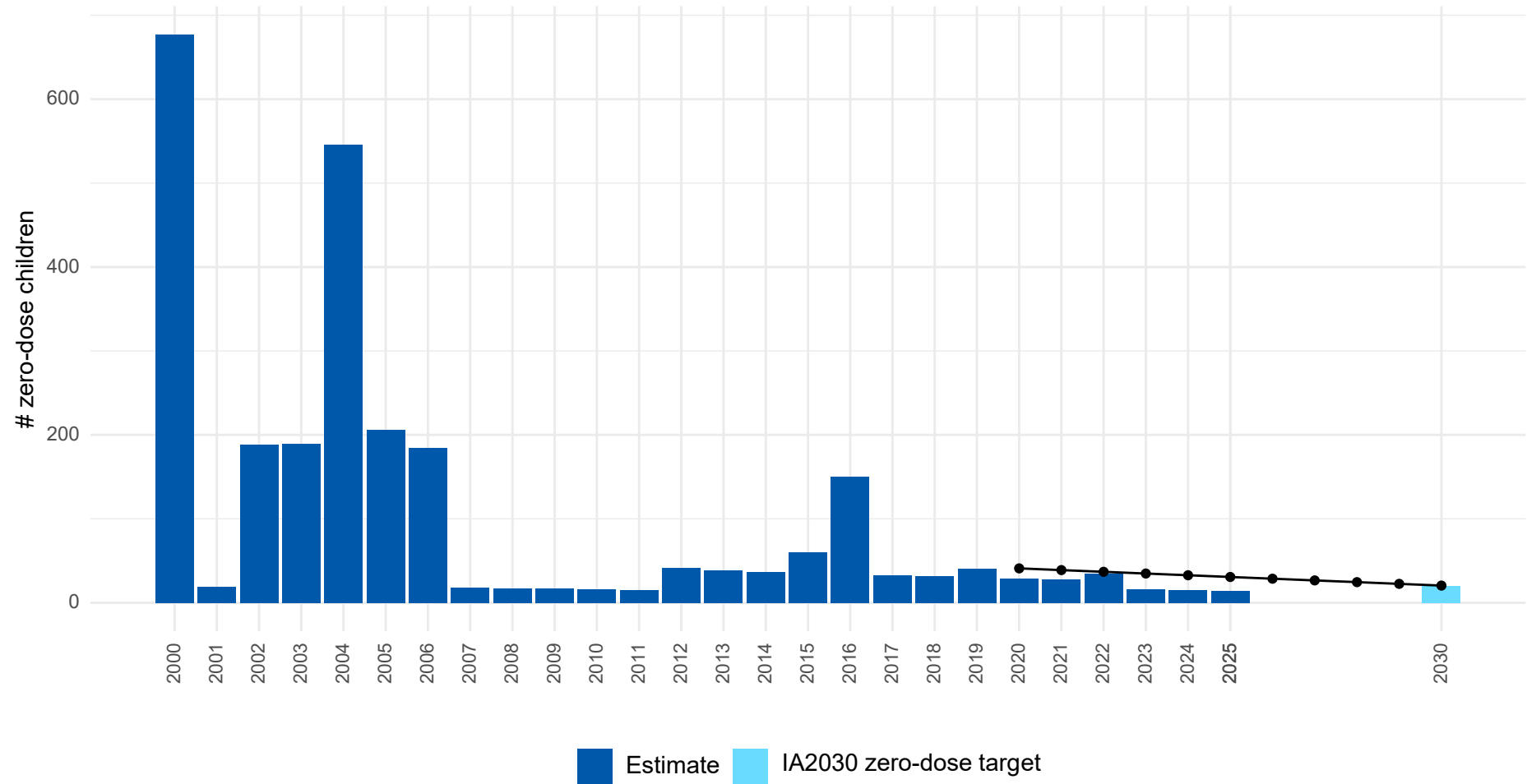
IA2030 calls on all countries to reduce the number of zero dose children in 2019 by half by 2030. This chart shows the annual number of children required to be vaccinated to reach the ZD target.

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.

Marshall Islands 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 54% below the annual IA2030 goal, positioning the programme to reach, and potentially exceed the 2030 goal if current progress continues.

Estimated number of zero-dose children, 2000-2025 and target by 2030, Marshall Islands



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 54% lower than (ie. the country had achieved) the annual number proposed to reach the target, based on a linear trajectory of decline.

With the number of surviving infants remaining relatively stable in recent years, coverage can be sustained by vaccinating similar numbers of children that are currently being reached, while improving coverage requires further reach.

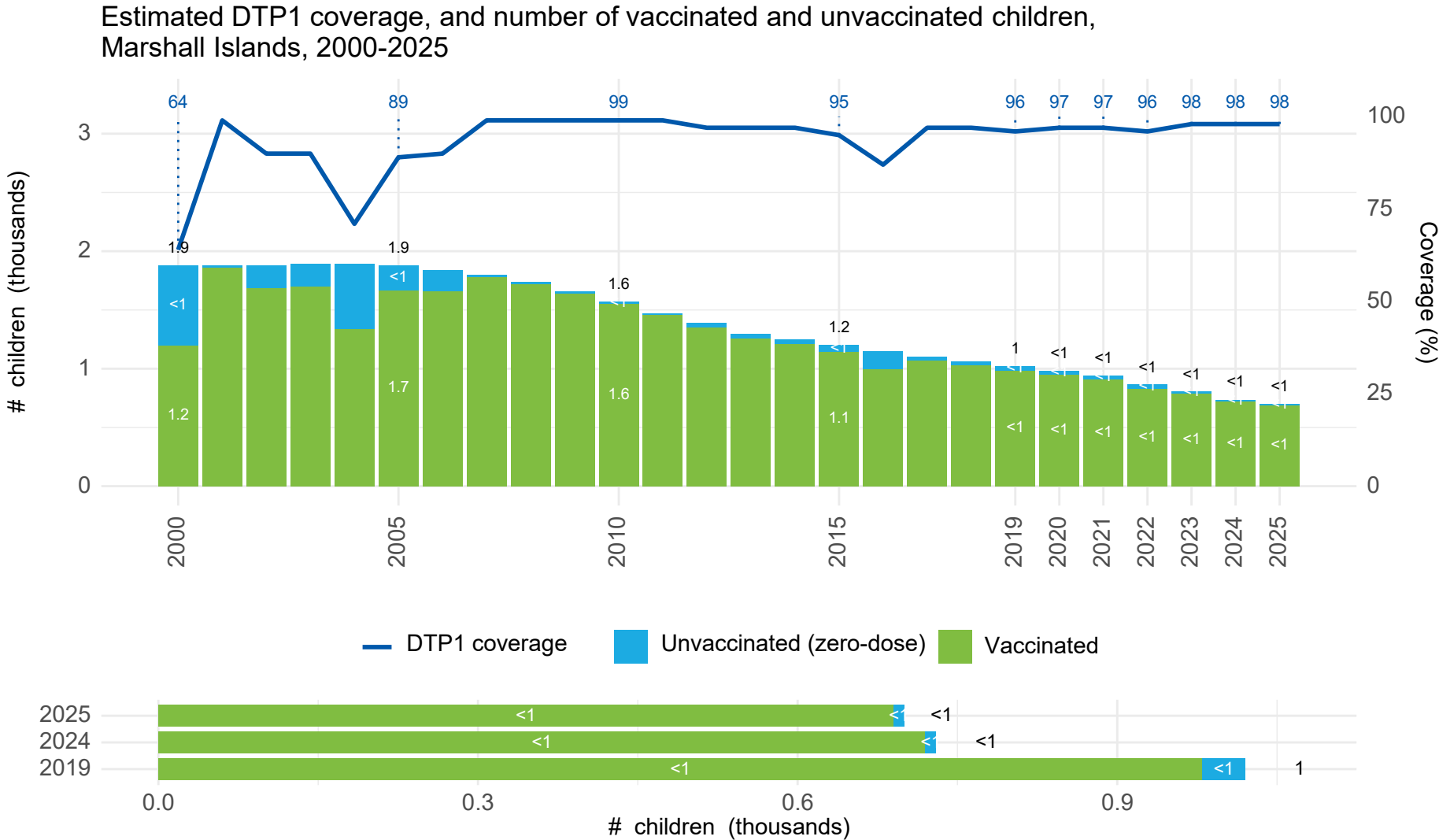
DTP1 coverage in 2025 (98%) was higher than in 2019 (96%).

The number of children vaccinated with DTP1 decreased between 2019 and 2025.

The number of surviving infants decreased between 2019 and 2025.

In 2025, fewer children were vaccinated than in 2019.

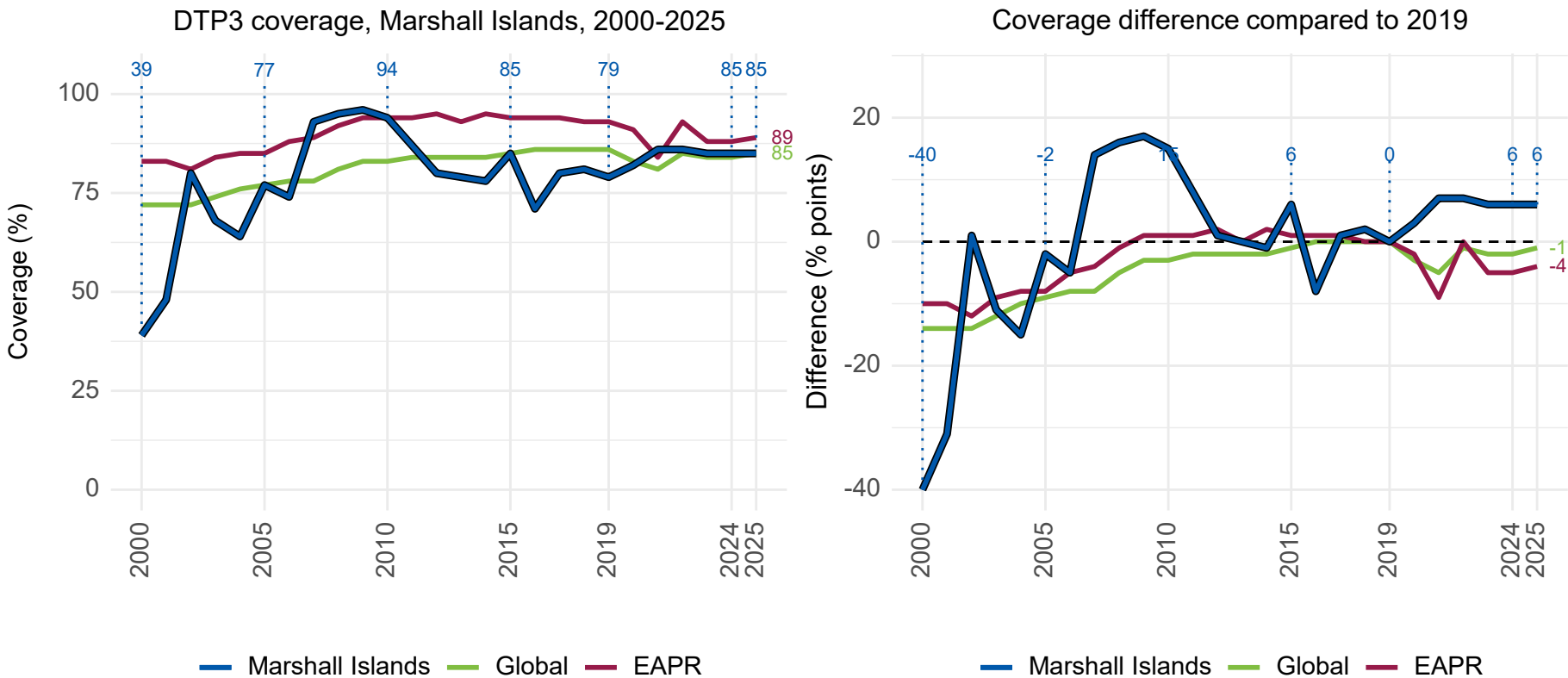
In 2025, there were fewer surviving infants (target population) than in 2019.



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

DTP3

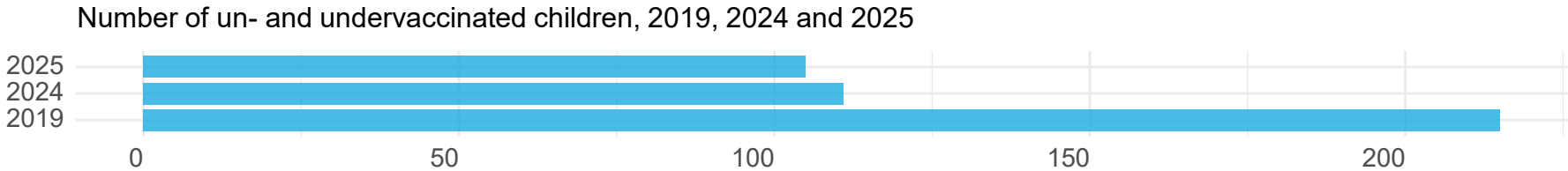
In 2025, Marshall Islands DTP3 coverage was 85% - this is 6 percentage points higher than in 2019 and the same as the global average.



In 2025, DTP3 coverage in Marshall Islands (85%) was the same as the global average and 4 percentage points lower than the average across all EAPR countries (89%).

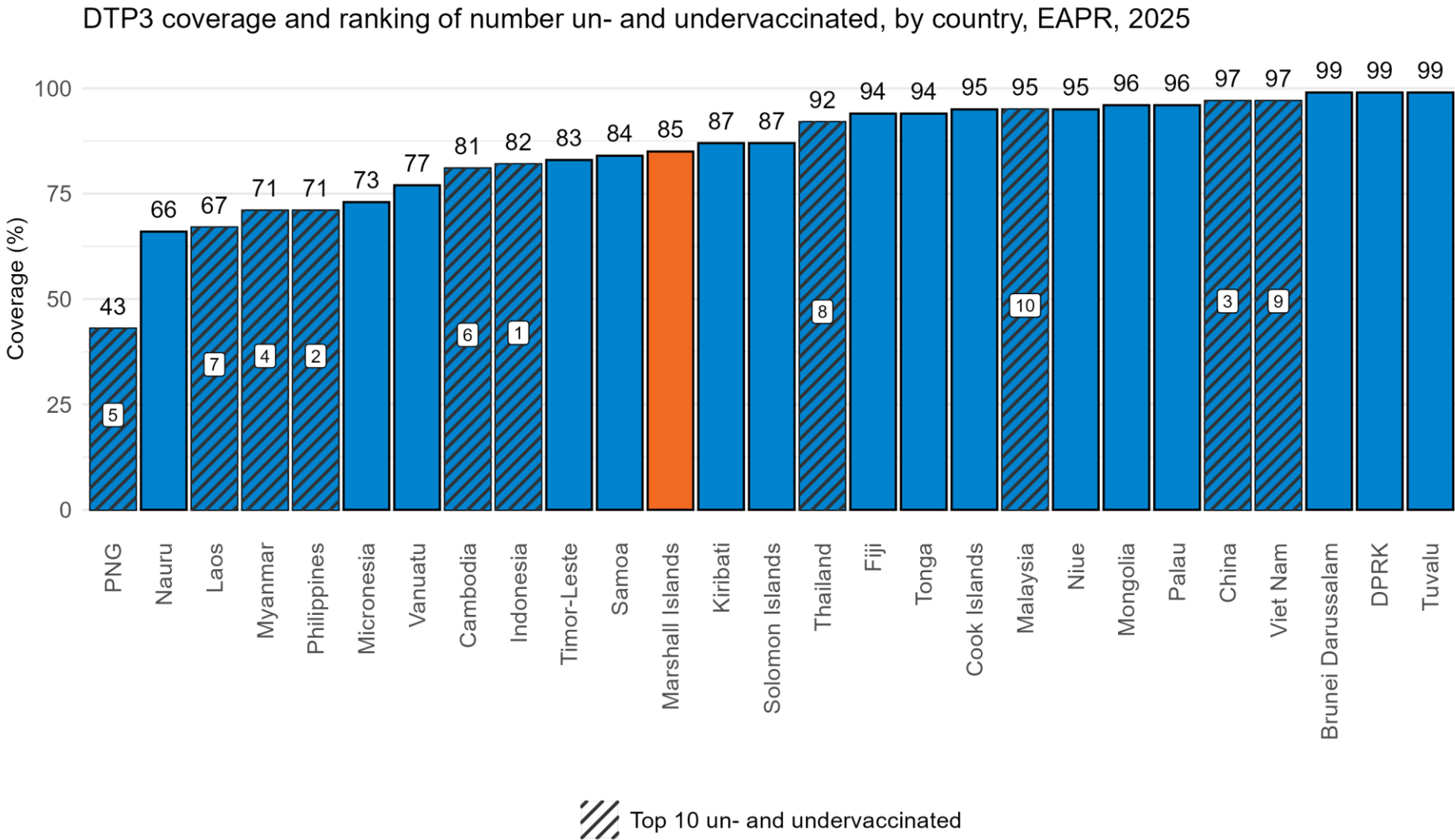
National DTP3 coverage was 6 percentage points higher than in 2019 (79%).

The number of un- and undervaccinated children declined (ie. improved) compared to 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, Marshall Islands was among the countries with the highest coverage and was not among the top 10 countries with the highest number of un- and undervaccinated children in the region.



This chart shows DTP3 coverage in countries in EAPR 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, Marshall Islands ranked number 12 out of 27 countries for lowest DTP3 coverage (based on tied ranks).

Marshall Islands was not in the top 10 countries with the most un- and undervaccinated children.

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.

With the number of surviving infants remaining relatively stable in recent years, coverage can be sustained by vaccinating similar numbers of children that are currently being reached, while improving coverage requires further reach.

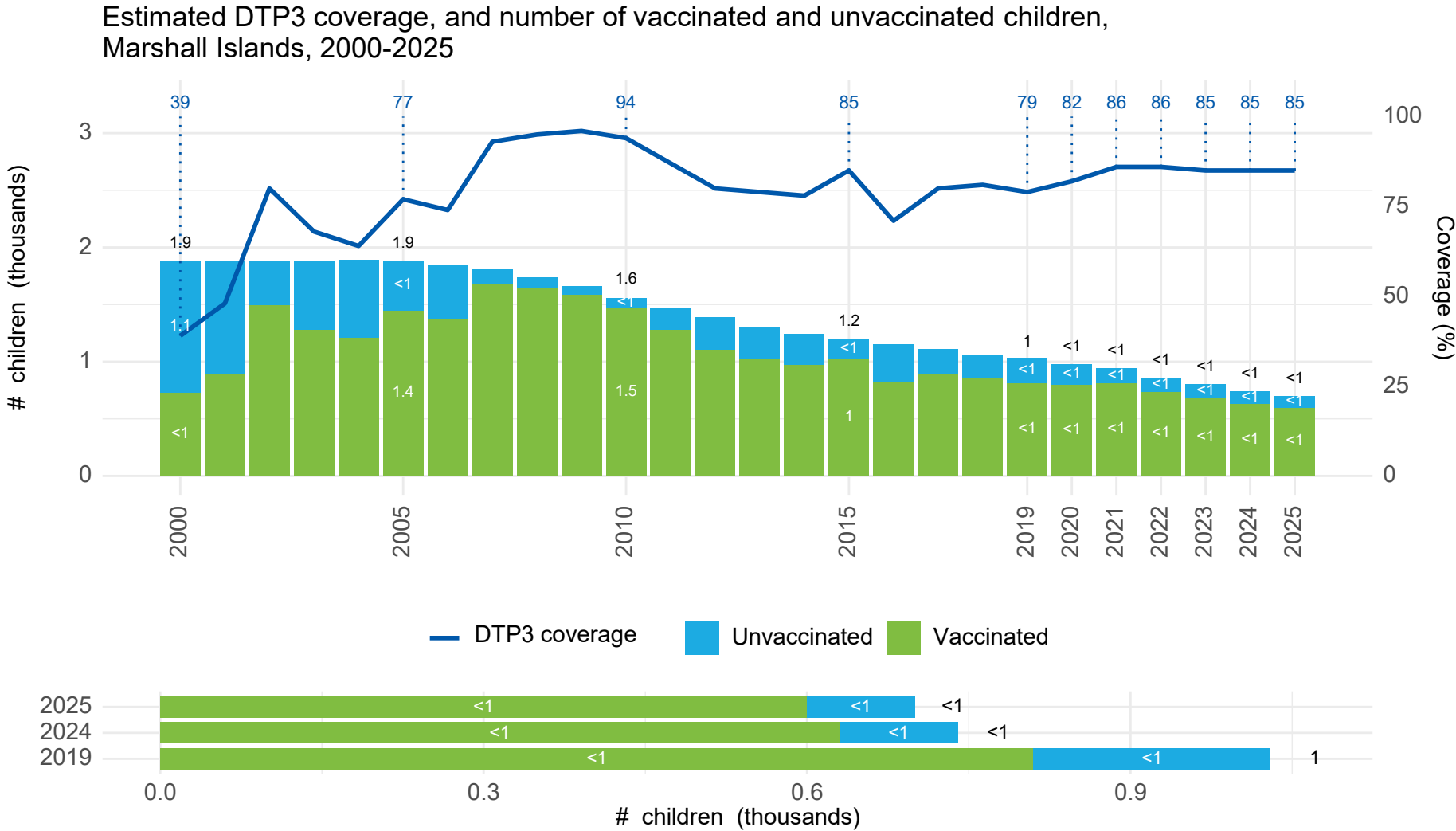
DTP3 coverage in 2025 (85%) was higher than in 2019 (79%).

The number of children vaccinated with DTP3 decreased between 2019 and 2025.

The number of surviving infants decreased between 2019 and 2025.

In 2025, fewer children were vaccinated than in 2019.

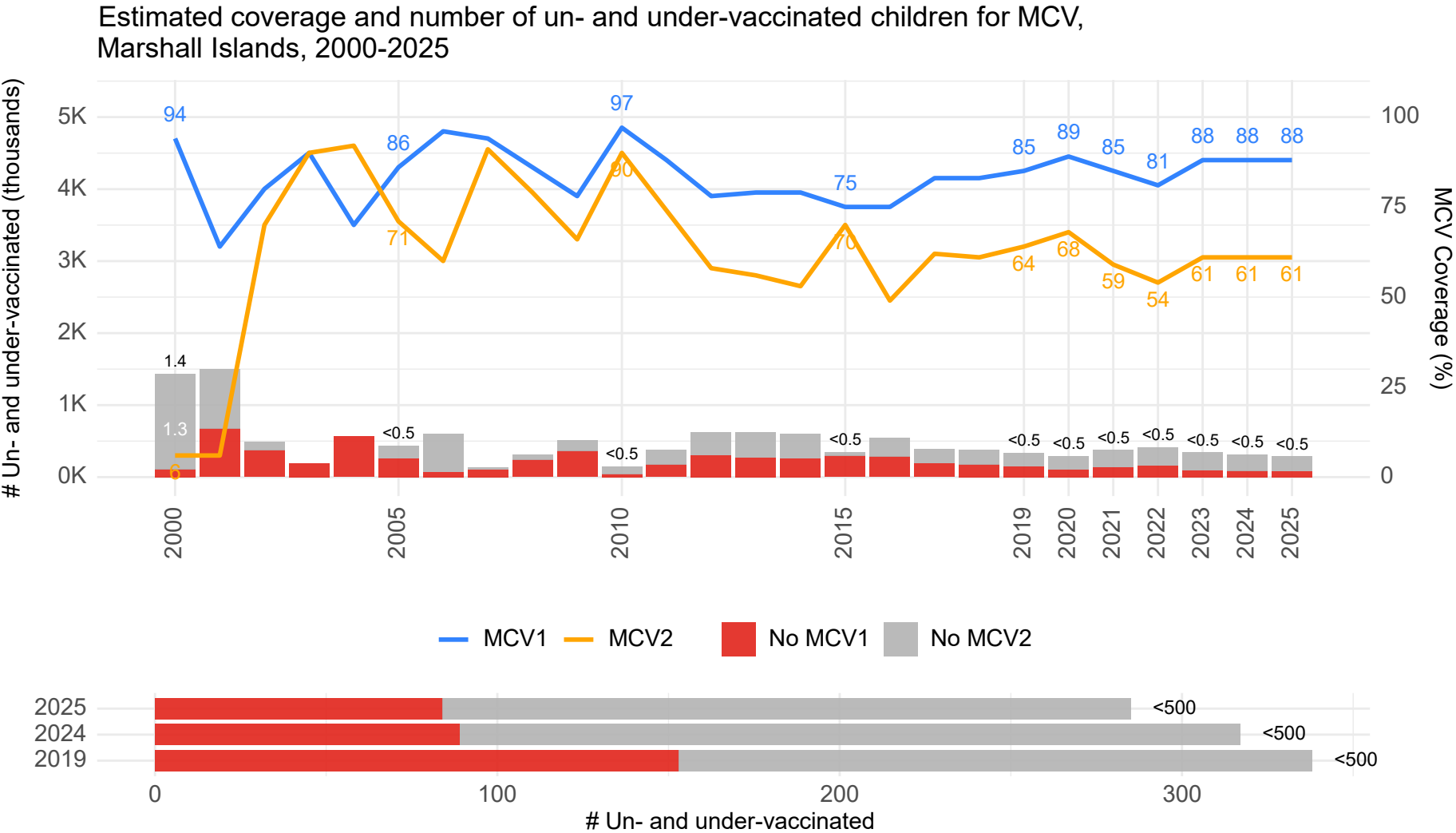
In 2025, there were fewer surviving infants (target population) than in 2019.



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

MCV1

MCV1 coverage remained constant at 88% in 2025 - below the 95% level needed to prevent outbreaks and, leaving <100 children without any protection against measles. MCV2 coverage also remained constant at 61% - 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.

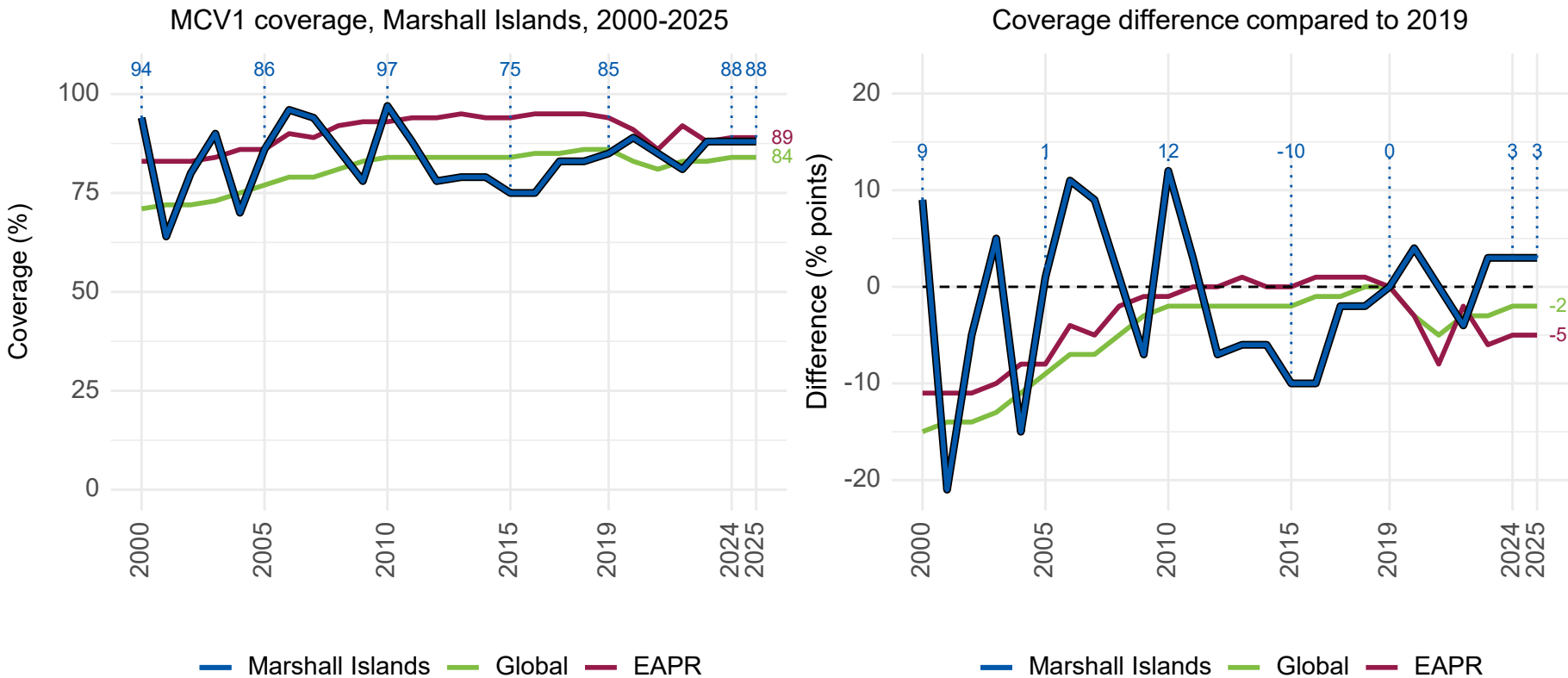
Measles, because of its high transmissibility, acts as a 'canary in the coalmine', quickly exposing any immunity gaps in the population. The coverage of measles containing vaccine (MCV) is thus often used as a tracer for protection.

The percentage of children receiving MCV1 – typically at 9 or 12 months depending on the national vaccination schedule – remained constant at 88%. This is greater than in 2019, where coverage was 85%.

<100 children missed their routine first dose of measles vaccine.

MCV2 is typically administered to children between 18 months and five years old. MCV2 coverage remained constant at 61% in 2025.

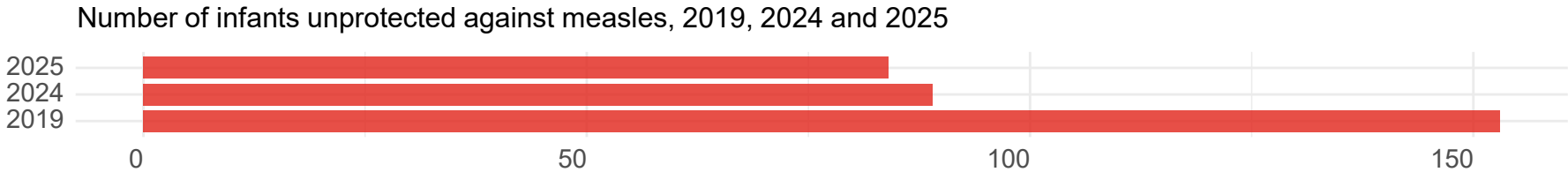
In 2025, Marshall Islands MCV1 coverage was 88% - this is 3 percentage points higher than in 2019 and 4 percentage points higher than the global average (84%).



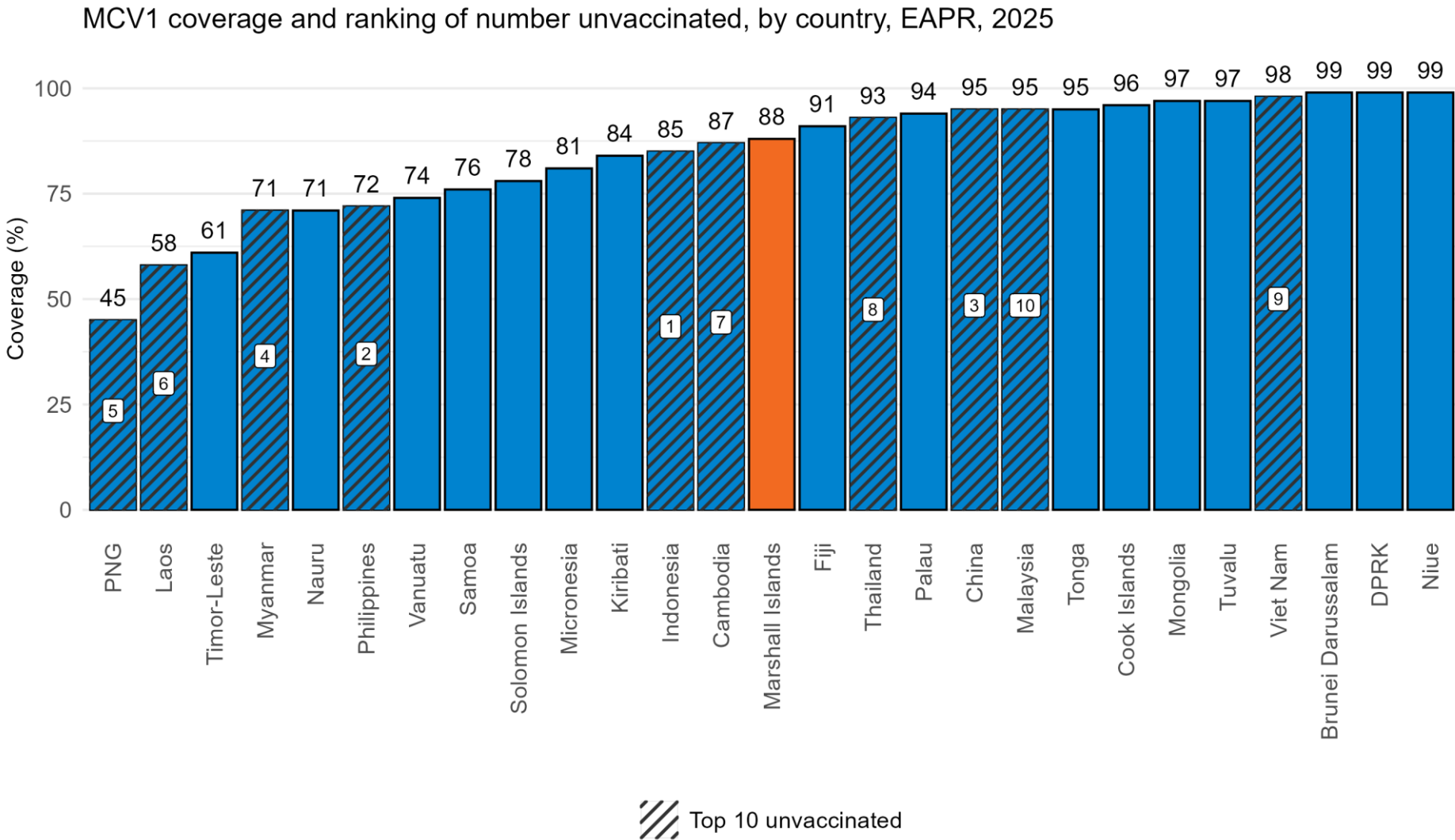
In 2025, MCV1 coverage in Marshall Islands (88%) was 4 percentage points higher than the global average (84%) and 1 percentage point lower than the average across all EAPR countries (89%).

National MCV1 coverage was 3 percentage points higher than in 2019 (85%).

The number of unvaccinated children declined (ie. improved) compared to in 2019.



In 2025, Marshall Islands 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 EAPR from lowest to highest coverage, and the rank of the top 10 countries with the most unvaccinated children, based on absolute numbers.

In 2025, Marshall Islands ranked number 14 out of 27 countries for lowest MCV1 coverage (based on tied ranks).

Marshall Islands 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.

With the number of surviving infants remaining relatively stable in recent years, coverage can be sustained by vaccinating similar numbers of children that are currently being reached, while improving coverage requires further reach.

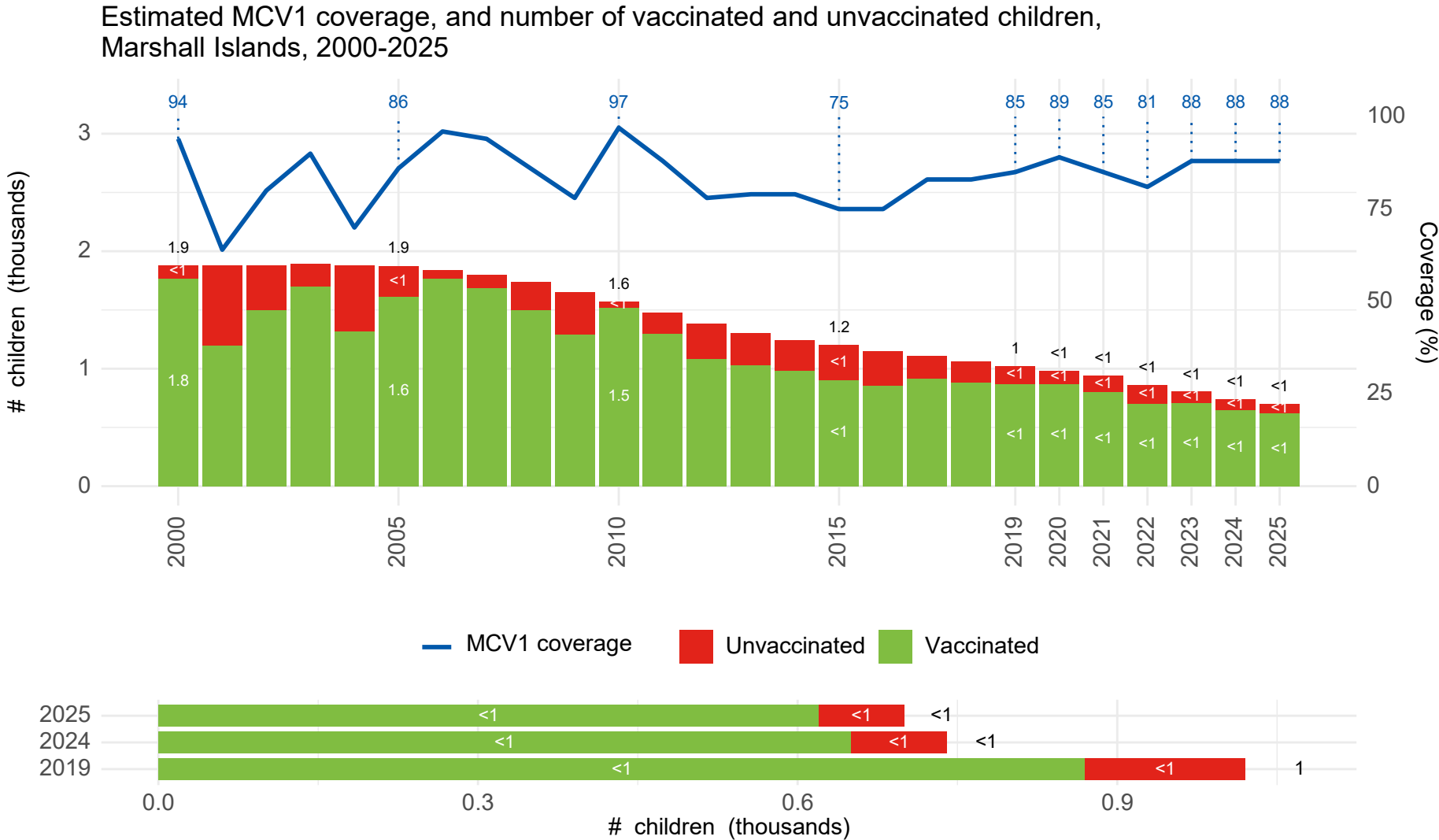
MCV1 coverage in 2025 (88%) was higher than in 2019 (85%).

The number of children vaccinated with MCV1 decreased between 2019 and 2025.

The number of surviving infants decreased between 2019 and 2025.

In 2025, fewer children were vaccinated than in 2019.

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

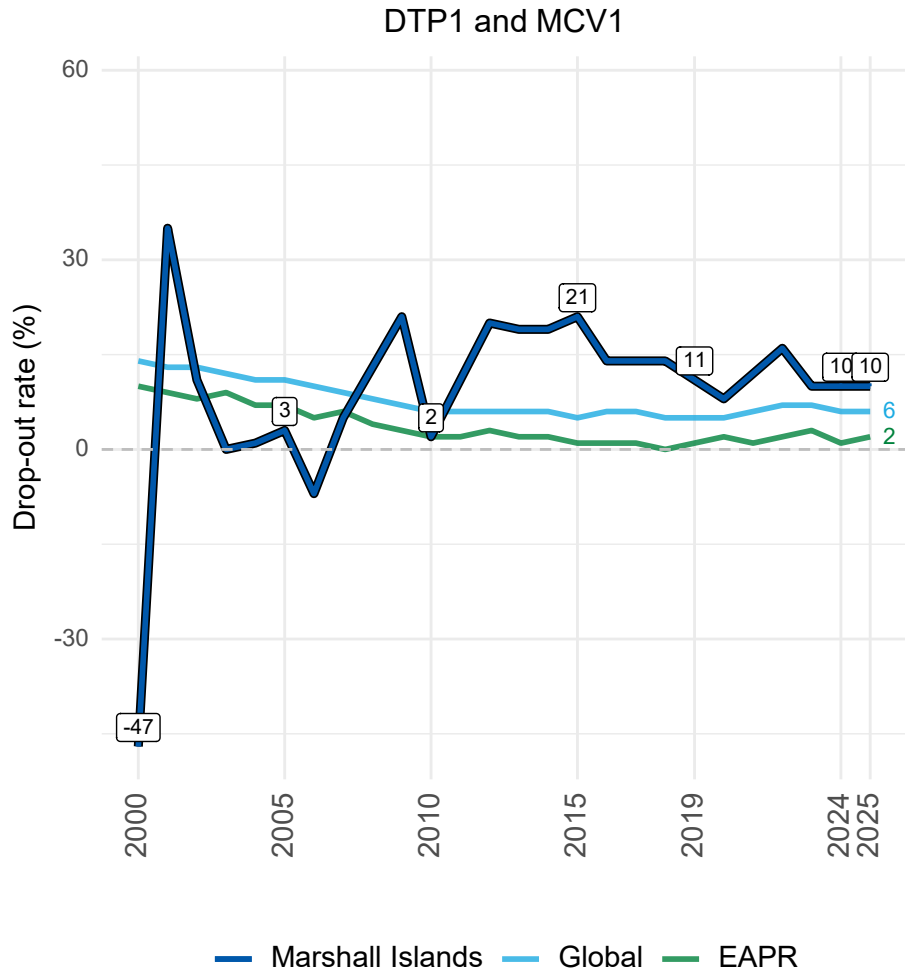
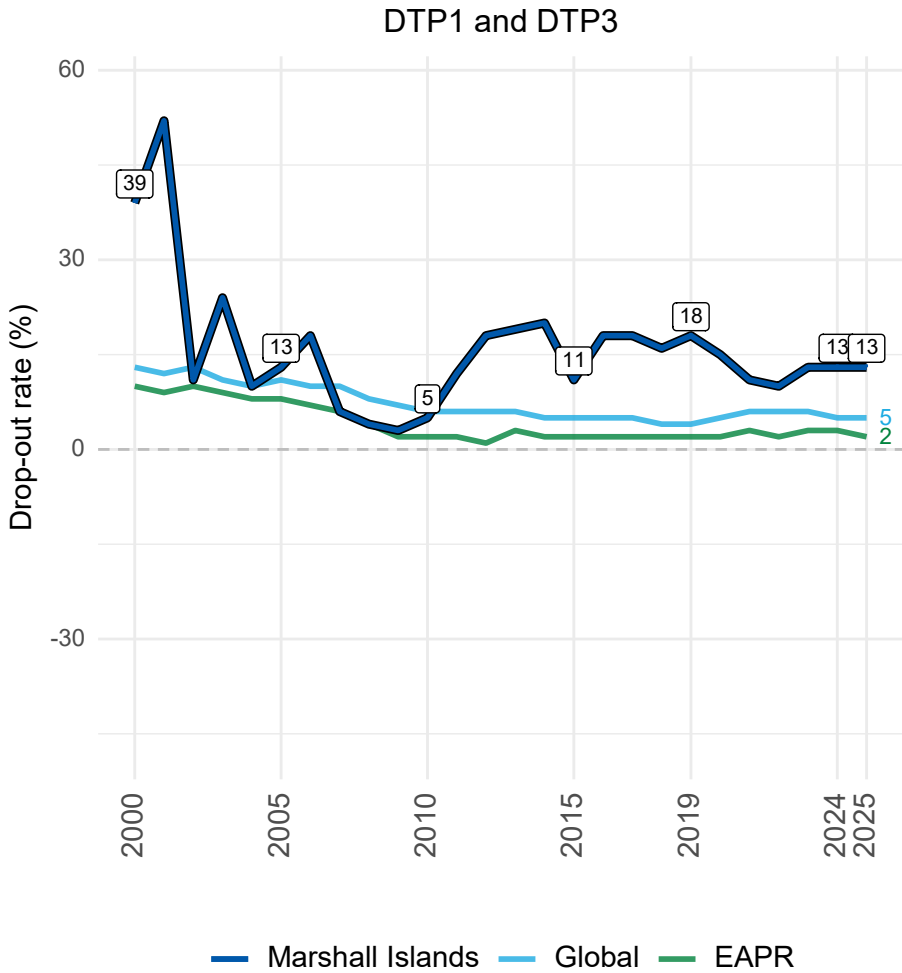


Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision

# Childhood immunization: Additional charts

In 2025, DTP1-DTP3 drop-out was high (13%) and DTP1-MCV1 drop-out was moderate (10%) in Marshall Islands, indicating poor ability to deliver the primary series early on, but moderate 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.

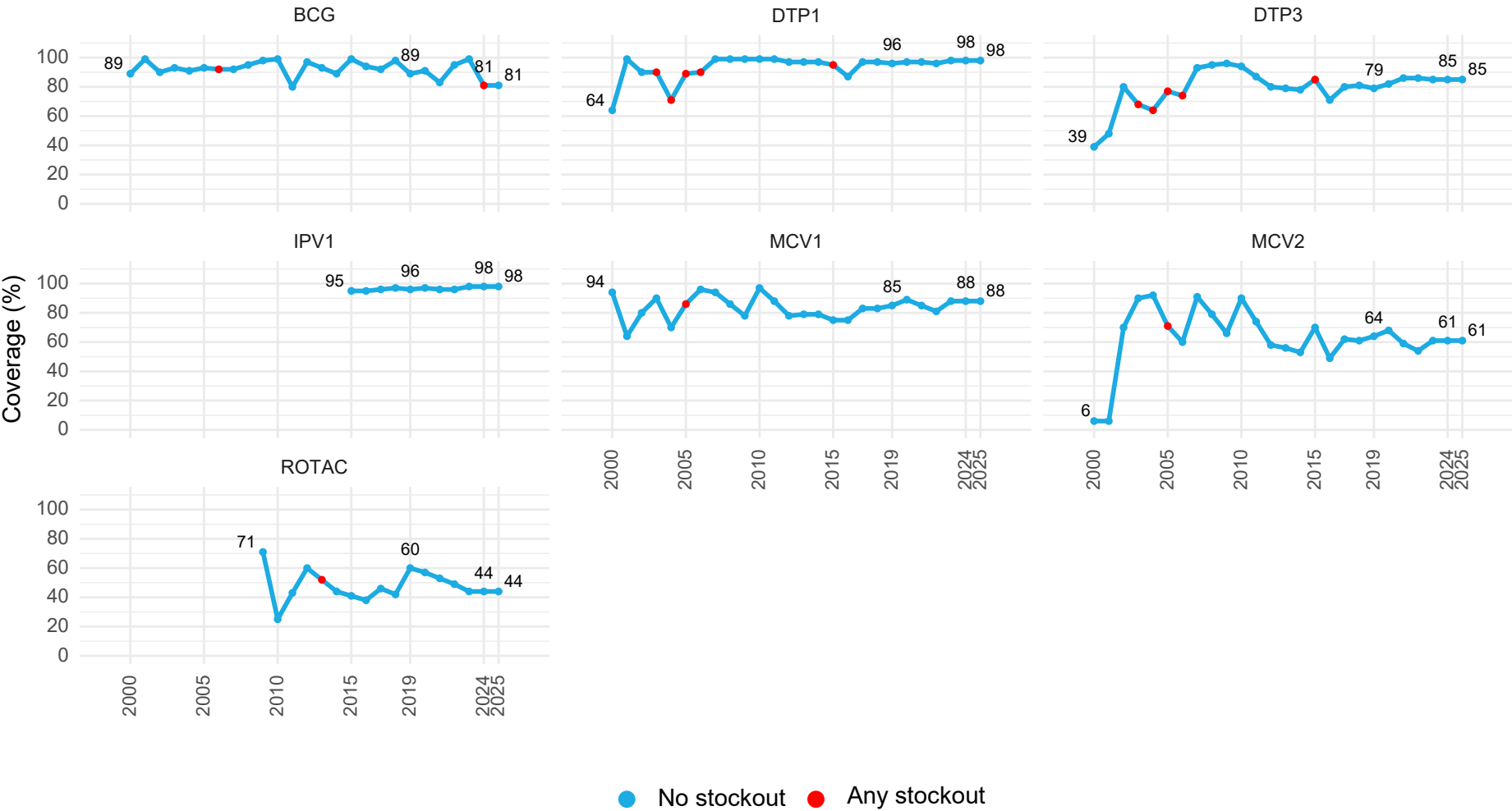
In 2025, 13% of children who received DTP1 did not receive DTP3 (left), and 10% of children who received DTP1 did not receive MCV1 (right).

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

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

In 2025, Marshall Islands had its lowest coverage in ROTAC (44%), while most other routine vaccines clustered around 61-98%; 4 antigens increased since 2019, and 7 antigens remained constant since 2024.

Coverage of recommended childhood vaccines, Marshall Islands, 2000-2025



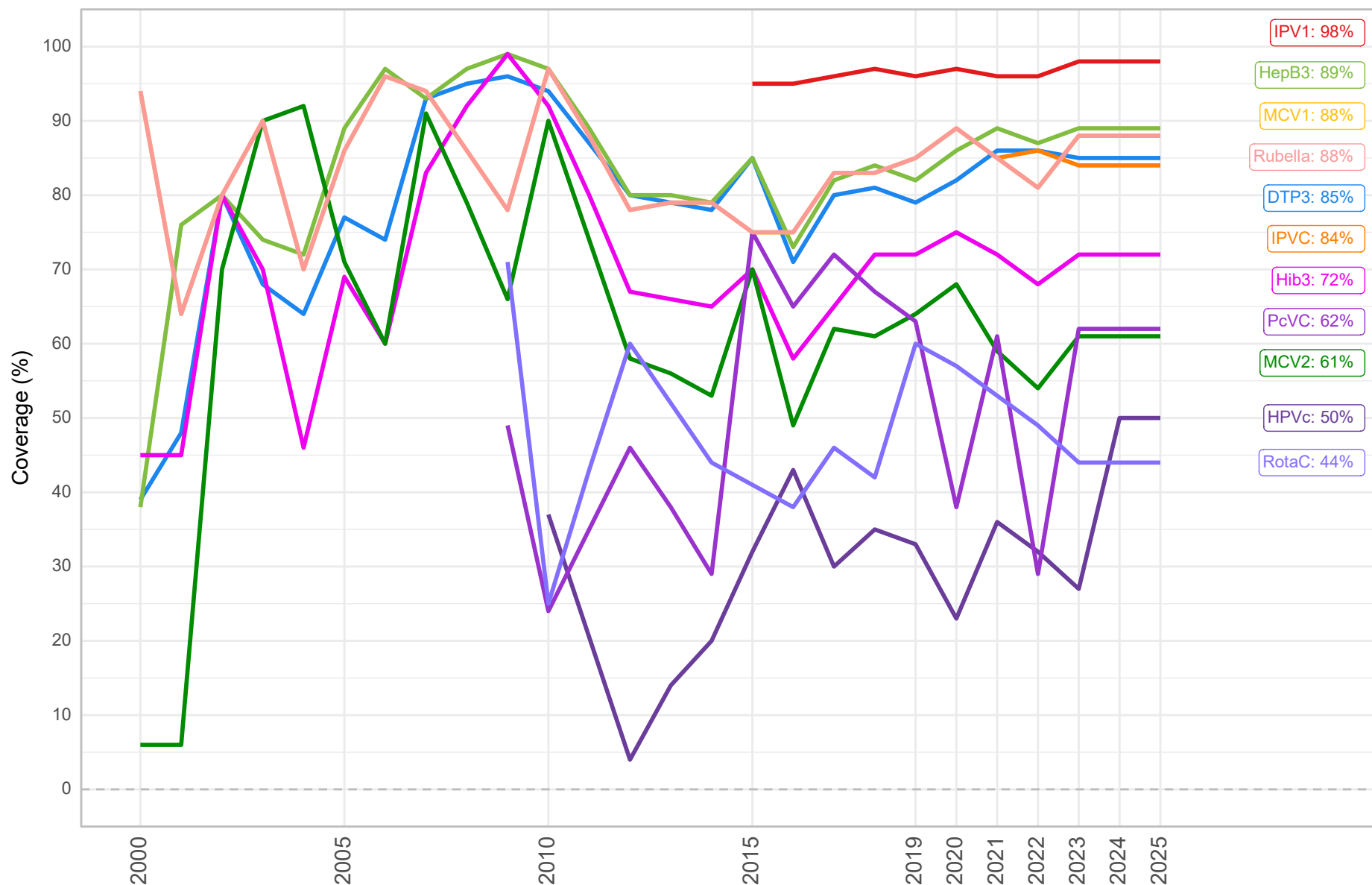
This chart shows trends in coverage of selected core routine vaccines recommended in childhood.

In 2025, ROTAC had the lowest coverage (44%), followed by MCV2 (61%).

Compared to 2019, coverage of 3 vaccines decreased (BCG, MCV2 and ROTAC) and 4 vaccines increased (DTP1, DTP3, IPV1 and MCV1).

Compared to 2024, coverage of 7 vaccines remained constant (BCG, DTP1, DTP3, IPV1, MCV1, MCV2 and ROTAC).

Vaccine coverage (%), Marshall Islands, 2000-2025



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision  
Numbers in the data label bubbles refer to vaccine coverage in the latest year estimates are available.

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

In 2025, RotaC had the lowest coverage of all vaccines (44%), followed by HPVc (50%).

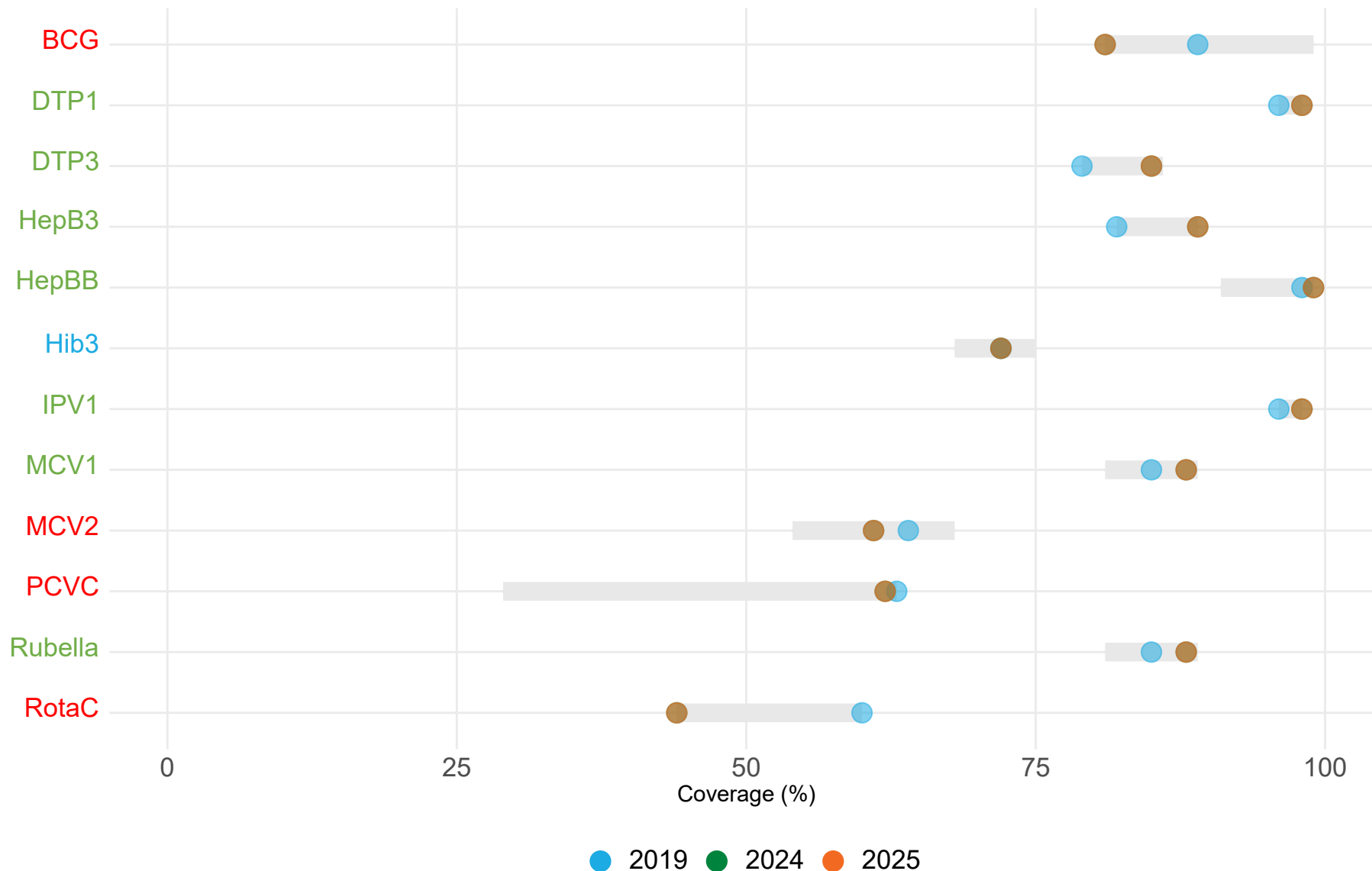
Coverage of 6 vaccines increased (DTP3, HEPB3, HPVc, IPV1, MCV1 and RUBELLA), 1 vaccine was the same (HIB3), and 2 vaccines decreased (MCV2 and ROTAC) compared to respective coverage in 2019.

Coverage of 10 vaccines were the same (DTP3, HEPB3, HIB3, HPVc, IPV1, IPVC, MCV1, MCV2, ROTAC and RUBELLA) compared to respective coverage in 2024.



WUENIC 2025 revision

## Vaccine coverage (%), Marshall Islands, 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 (96%) and 2024 (98%). DTP1 coverage remained the same in 2025 (98%) compared to 2024, and was higher than in 2019. In 2019-2025, DTP1 coverage was at its lowest level in 2019 and 2022 (96%).

In 2024, 4 vaccines had lower coverage than in 2019.

In 2025, 4 vaccines had lower coverage than in 2019.

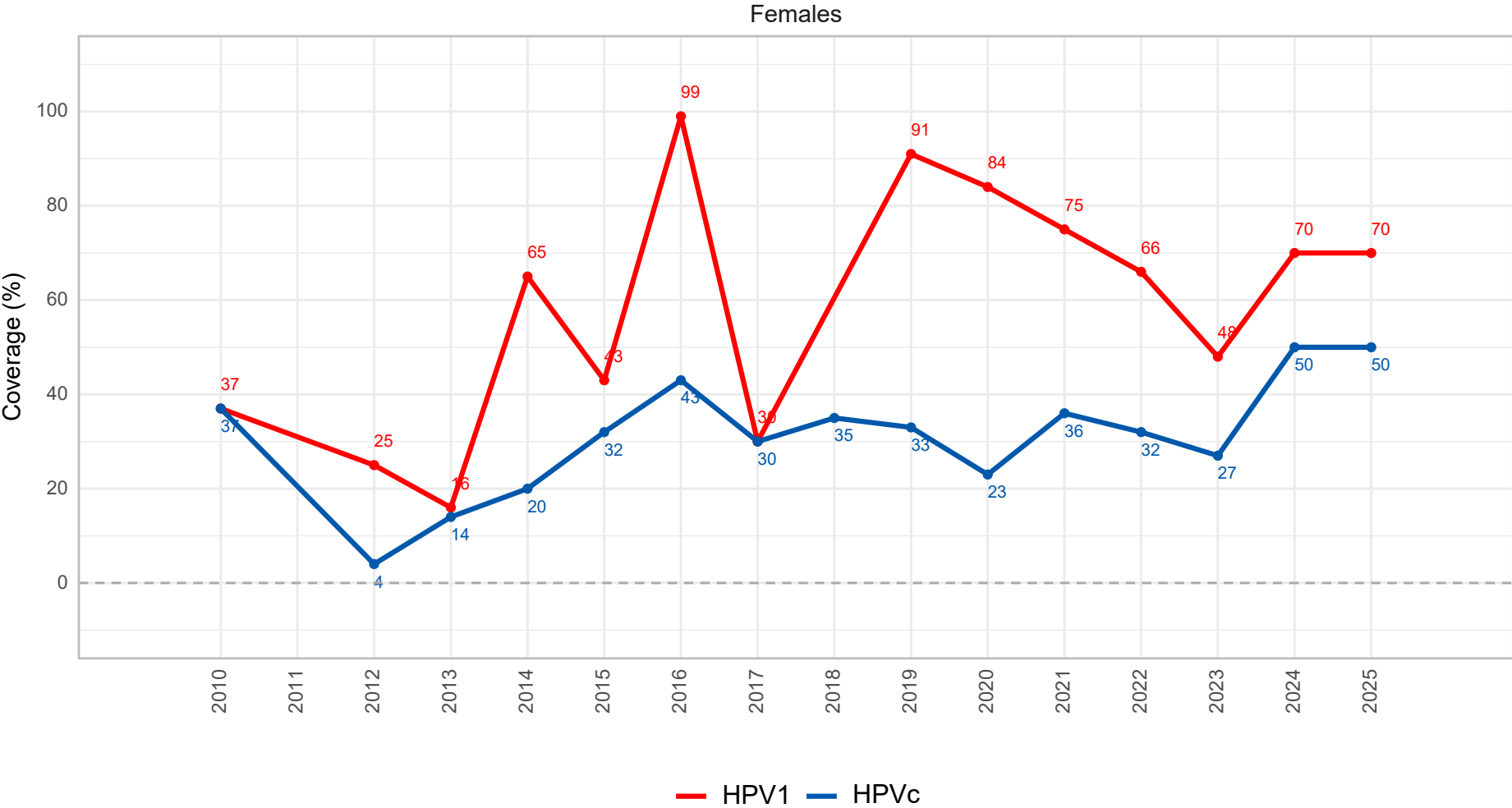
In 2025, 0 vaccines had lower coverage than in 2024.

# 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 50%.

Human papillomavirus (HPV) vaccine coverage (%), Marshall Islands, 2010-2025



The first year of HPV programme coverage estimates in Marshall Islands was 2010.

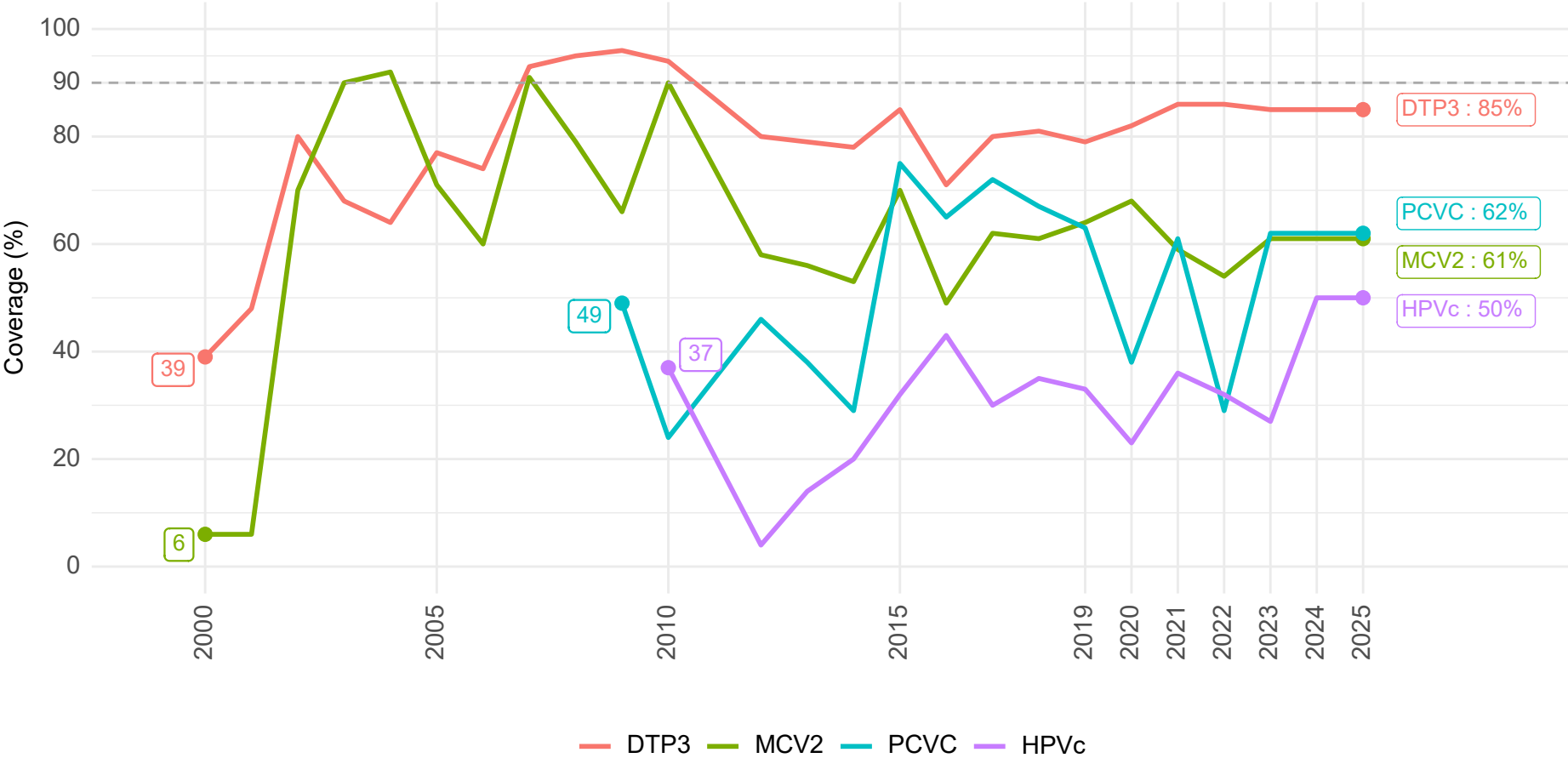
In 2025, first dose (HPV1) programme coverage among girls was 70%. In 2025, last dose (HPVc) programme coverage among girls was 50%.

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, no SDG vaccines in met the 90% SDG coverage target.

SDG 3.b.1: Proportion of the target population covered by all vaccines included in their national programme, Marshall Islands, 2000-2025



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.

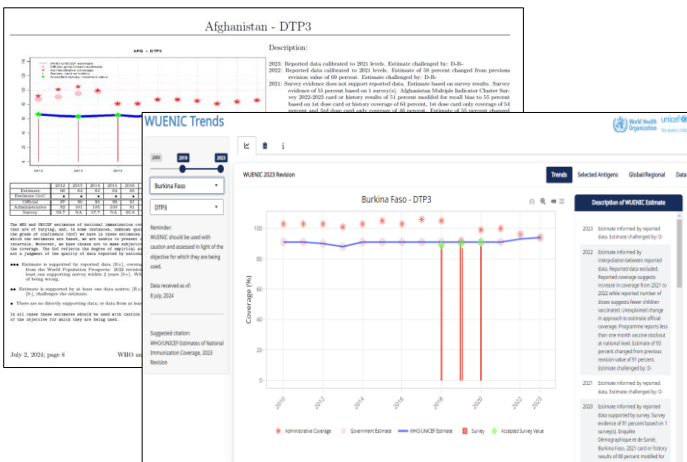
The IA2030 global target is 90% coverage of all four antigens by 2030.

Marshall Islands has all 4 of the SDG vaccines.

In 2025, Marshall Islands had achieved at least 90% coverage of none out of the 4 vaccines.

Additional resources

## WUENIC country profiles (PDF and interactive versions)

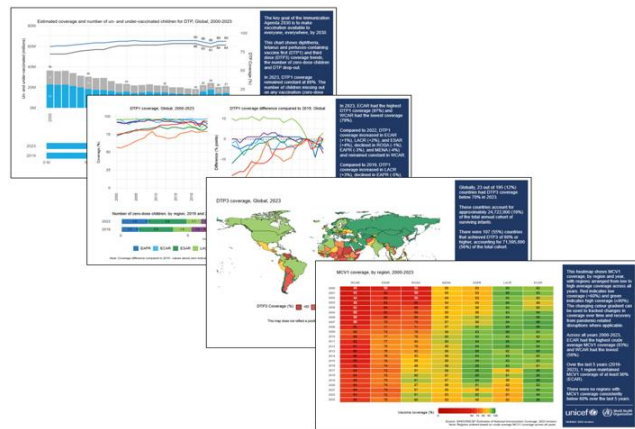


## Datasets: WUENIC, HPV, survey database

|    | 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 |   |
| 22 | ROSA              | AFG     | Afghanistan bcg | 2002 | births     |          |            |              |           |   |

## 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/>

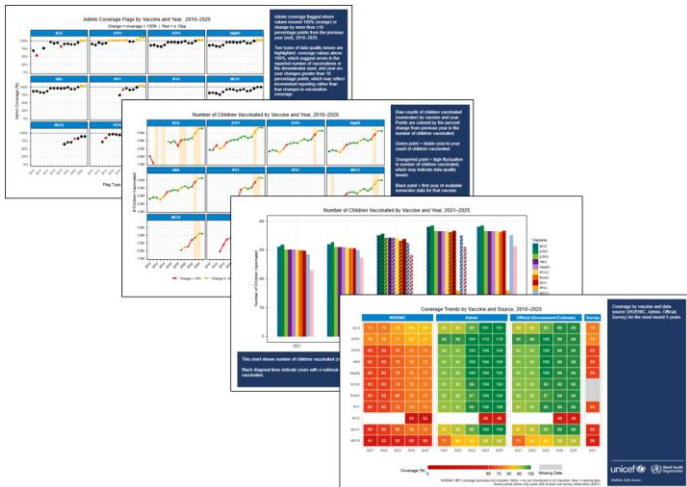
## Interactive immunization regional snapshots:

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



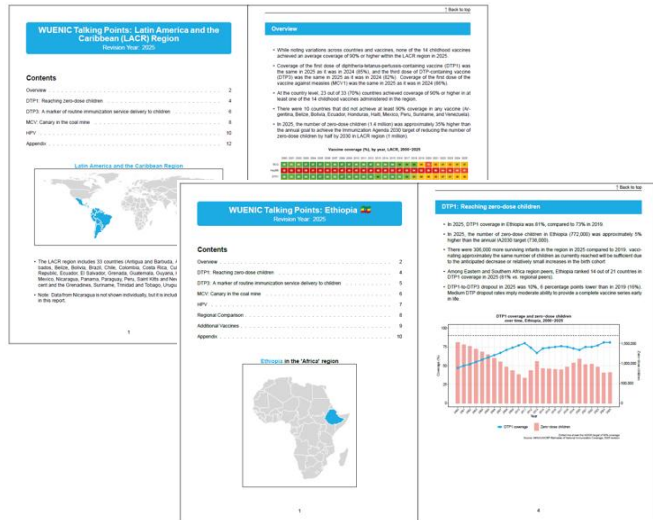
## Country data quality reports

(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>

