We can't kick out malaria while ignoring PWDs

As Uganda joins the rest of the world to commemorate World Malaria Day 2026 on April 25 in Iganga District, the urgency of this year's global theme: "Driven to end malaria. Now we can. Now we must."- could not be more fitting. Coupled with Uganda's national call for "Zero Malaria Deaths," the moment demands not only renewed commitment, but a deeper reflection: who is still being left behind in the fight against malaria?

Women and girls with disabilities often face multiple and intersecting barriers: poverty, stigma, limited mobility, and exclusion from mainstream health communication systems. In malaria prevention and treatment, these barriers translate into:

Reduced access to insecticide-treated mosquito nets, limited access to timely diagnosis and treatment, exclusion from public health messaging that is not disability-inclusive.

Increased exposure due to dependence on caregivers or unsafe living conditions.

While Uganda has made strides in malaria control; through mass net distribution, indoor residual spraying, and community health interventions, these efforts are not always designed with disability inclusion in mind.

For instance, a standard health campaign may distribute mosquito nets, but does it ensure that a visually impaired woman understands how to use it properly?

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Elizabeth Kayanga
World Malaria Day

A radio message may promote early treatment, but does it reach a deaf adolescent girl in a rural household?

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The aspiration of zero malaria deaths cannot be achieved through a one-size-fits-all approach. It requires equity-driven strategies that prioritise those most at risk of being excluded.

Women and girls with disabilities are not just passive beneficiaries- they are critical actors in community health systems. When empowered, they can: Champion malaria prevention practices within households, support community surveillance and reporting, influence social norms that shape health-seeking behaviour. However, this potential can only be realised if systems are accessible, inclusive, and responsive.

As Uganda moves from commitment to action, several priority areas must shape the next phase of malaria response.

Disability-inclusive health communication: Malaria messages must be adapted into accessible formats-sign language interpretation, braille materials, simplified visuals, and community-based interpersonal communication.

Inclusive service delivery: Health facilities and outreach programmes must be equipped to serve persons with disabilities— physically accessible spaces, trained health workers, and respectful care.

Data that counts everyone: Current malaria data rarely disaggregates by disability. Without this, WGDs remain statistically invisible, and policy responses remain incomplete.

Partnerships with organisations of persons with disabilities play a critical role in bridging gaps between policy and lived realities. Their involvement should be institutionalised, not incidental. The fight against malaria is at a defining moment. The tools exist: effective treatment, preventive measures, and growing political will. As the global theme reminds us, "Now we can. Now we must." But we must also ask: Can we truly end malaria if some lives remain unseen, unheard, and under-served?

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