KERATAN AKHBAR 1/02/2026 (Ahad)

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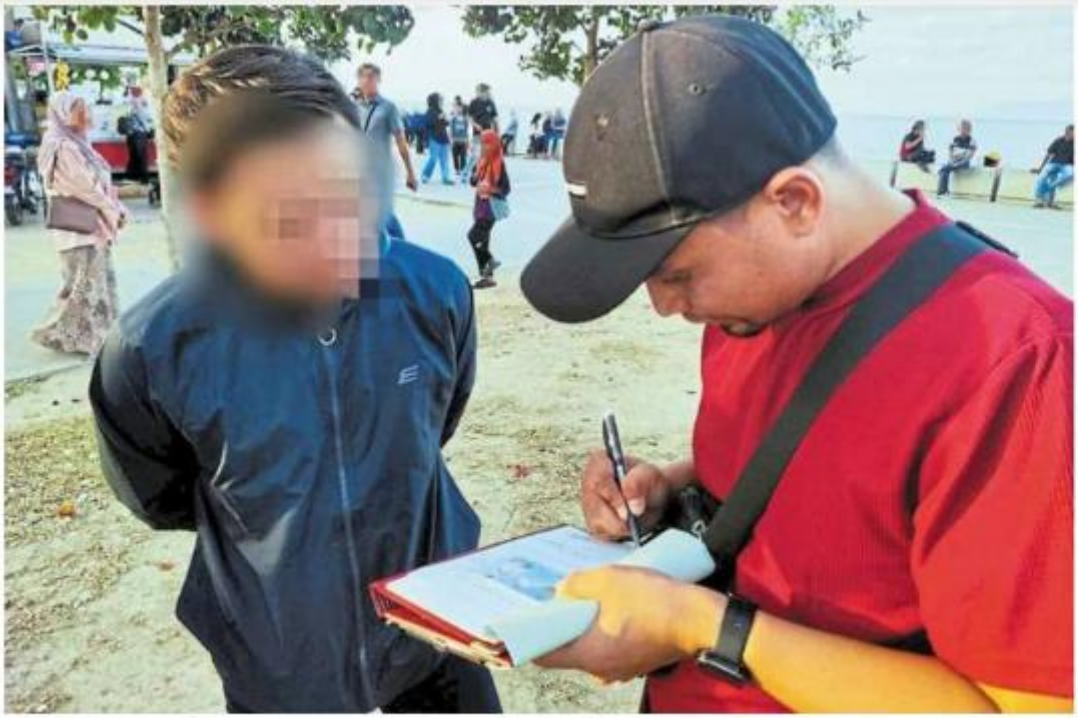

Smoke-free area: An enforcement officer issuing a compound to an individual within the Penang heritage zone. — Photo courtesy of the Penang Health Department

RM41,800 in fines issued in a day

By ARNOLD LOH
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GEORGE TOWN: Compliance to no-smoking rules within the Penang heritage zone is dropping, says the state's Health Department.

In a statement, the department said that Jan 24 illustrated the point, with enforcement officers issuing RM41,800 in compounds in a single day after detecting 174 offences during an anti-smoking operation at the heritage enclave here.

With the heritage zone here designated a Penang Smoke-Free Area since July 4, 2015, a total of 112 premises were inspected during the operation, which involved 99 enforcement personnel.

The operation was conducted under the Control of Smoking Products for Public Health Act 2024 (Act 852), which came into effect on Oct 1, 2024 along with expanded smoke-free zones, among other regulatory measures.

Actions taken included 108 notices requiring offenders to attend court, 35 notices for smoking in prohibited areas and three notices issued to underage individuals for smoking.

Action was taken against premises owners, with 27 notices issued for failing to display no-smoking signage and one notice issued for providing a smoking space at a premises where smoking was prohibited.

In a related development, two premises owners were prosecuted in court for failing to display notices prohibiting the sale of tobacco products, smoking materials or tobacco substitutes to individuals below the age of 18 at sales counters.

Both premises were fined a total of RM2,300.

From 2023 to Dec 23, 2025, a total of 304 compounds were issued to smokers within the heritage zone, with 74 issued in 2023, 124 in 2024 and 106 in 2025.

Addressing crisis behind late pregnancy registration

SABAH VOICE

By Melvin Ebin Bondi

Placing the burden of maternal health solely on mothers is both unfair and ineffective. — Bernama photo

IN the rural interior of Kampung Inarad in Tongod, pregnancy rarely begins with a clinic card or an appointment date.

It begins quietly, with a missed period, morning sickness that comes and goes, and fatigue often explained away as farm work or long days running a household.

For many women, the nearest health clinic is hours away along unpaved roads or logging tracks; transport costs money; and the decision to seek care is not always theirs alone.

When national conversations turn to healthcare reform, digital records or policy targets set for 2026, these words often never reach the communities most affected; or if they do, they feel distant and abstract.

The reality on the ground is far more immediate, shaped by a single unspoken question of whether help can be reached in time if something goes wrong.

As Sabah moves deeper into 2026, we must confront a truth that remains deeply uncomfortable – this is still one of the most dangerous places in Malaysia to be a mother or a child.

While the country speaks confidently about progress and universal access, Sabah continues to record mortality outcomes that expose long-standing structural gaps that no slogan can hide.

In 2024, Sabah's under-five mortality rate stood at 12.1 deaths per 1,000 live births, among the highest in Malaysia, while in 2023 the maternal mortality ratio reached 36.6 deaths per 100,000 live births, the highest in the country.

These figures are often presented as ratios and trends, but in reality, they translate into something far more tangible: babies who never leave the hospital, mothers who do not survive childbirth, and families left asking how joy turned into grief within hours.

These deaths do not happen because Sabah lacks committed healthcare workers.

They occur in a system stretched across vast geography with limited manpower, where Sabah's doctor-to-population ratio remains close to 1-to-800, compared to the national target of 1-to-400.

The Health Ministry (MoH) projections indicate that Sabah would need more than 4,600 additional doctors just to reach the minimum level considered safe.

The strain is not confined to doctors alone, as assistant medical officers (AMOs), nurses, pharmacists and healthcare workers are similarly stretched thin, frequently covering multiple responsibilities across wide rural areas where staffing gaps disrupt follow-up and early intervention.

Infrastructure and staffing alone do not explain the full picture.

Hidden within these mortality statistics is a quieter and less-discussed crisis that contributes directly to maternal death, namely late booking of pregnancy.

A review of maternal deaths in Sabah between 2015 and 2020 found that more than half of the women who died had never attended a single antenatal visit – meaning no blood tests, no blood pressure measurements, and no opportunity to detect danger early or prepare the body for childbirth.

Another layer of vulnerability involves women who are unregistered or lack formal documentation, including non-residents, who may delay or avoid antenatal care out of fear, uncertainty, or cost.

When pregnancies remain invisible to the health system, risks go un-assessed, complications go unmanaged, and opportunities for early intervention are lost.

In clinical practice, the first antenatal visit is known as the booking visit, and MoH training materials are explicit that this should occur when the pregnancy is still under 12 weeks.

This timing is not about paperwork or policy, but about biology.

Pregnancy is not a period of waiting, but a metabolic marathon in which blood volume expands rapidly, iron stores are depleted, and the cardiovascular system is forced to adapt quickly.

Conditions such as anaemia, hypertension and gestational diabetes often develop silently during early pregnancy, and without early assessment, they remain invisible until they surface as emergencies later in pregnancy or during labour.

Anaemia illustrates this risk clearly, with studies in Malaysia reporting anaemia in pregnancy at levels exceeding 50 per cent in some settings and consistently higher burdens observed in East Malaysia, where many women present with haemoglobin levels below the recommended 11.0g/dL threshold, often in the 8.0g/dL to 10.0g/dL range by the time they seek care, reducing oxygen delivery to vital organs and increasing the risk of death during childbirth itself.

Building blood reserves takes weeks, sometimes months, and when a woman presents for care only in her second or third trimester, that window is already closing.

If she haemorrhages during childbirth, even timely referral and emergency care may not compensate for blood that was never built.

Healthcare workers across Sabah see this pattern repeatedly, as women arrive in labour exhausted, severely anaemic and frightened, with no antenatal record and no baseline investigations.

Care becomes reactive rather than preventive, and when complications arise, the margin for rescue is dangerously narrow.

The reasons women book late, or not at all, are rarely simple.

Distance matters, and cost matters, but culture also plays a role that is often acknowledged quietly and avoided publicly.

In many Sabahan households, practical realities shape when care is sought.

A clinic visit may require someone else to take time off work, arrange transport, or cover fuel costs, and when early pregnancy appears uncomplicated, the urgency to attend is often delayed.

I also spoke to Abdul Hakim Mansor, a community health lecturer at MoE Training Institute in Kota Kinabalu, who offered a broader perspective on how pregnancy was understood at community level.

"Public health works best when prevention is built into everyday life, not treated as a response to illness.

"In maternal care, early engagement is about shifting mindsets from reacting to danger to anticipating it, which is why policy has long focused on getting women into care early rather than waiting for complications."

This is why placing the burden of maternal health solely on mothers is both unfair and ineffective.

In reality, the true gatekeepers of early booking are often husbands and family elders, and when a husband prioritises the first antenatal visit, everything changes.

Transport is arranged, money is found, and the appointment happens.

When he does not, booking is delayed, sometimes until complications force an emergency visit.

Research consistently shows that active partner's involvement improves clinic attendance, reduces maternal anxiety and increases adherence to medical advice, not by taking control away from women, but by recognising where decision-making power lies and using it to protect life.

Stories from clinics across Sabah reflect this clearly.

Some women arrive alone and apologetic, explaining that they are late because no one can bring them earlier, while others are present only after symptoms have worsened.

In contrast, women who attend early, often accompanied by supportive partners, are more likely to complete follow-up visits, take supplements consistently, and seek help promptly when warning signs appear.

None of this removes responsibility from the government.

It remains unacceptable that Sabah has far fewer government health clinics than other states with comparable geography such as Sarawak; and that specialist services remain concentrated in the urban centres while the rural districts struggle.

Budget 2026 announced that 4,500 contract doctors would be offered permanent posts, but the unresolved question for Sabah is whether underserved districts such as Sandakan, Kalabakan, Pitas, and interior divisions will see a fair share of this workforce.

But while policy decisions take time, pregnancies do not wait.

The tragedy is that late booking is one of the few risk factors for maternal death that can be changed quickly, because awareness costs little and understanding saves lives.

Knowing that the first 12 weeks matter changes behaviour, and recognising that pregnancy complications begin silently rather than dramatically creates urgency where there was once complacency.

Husbands need to understand that early booking is not excessive or optional, but protective; the elders must stop advising women to wait until the pregnancy 'feels safe'; employers must allow time off without penalty; and community leaders must repeat this message until it becomes normal.

Do not wait for the baby bump to show; do not wait for pain or bleeding; and do not wait until the second trimester – book before 12 weeks.

The maternal and child mortality gap in Sabah will only close if action comes from both sides, with the state strengthening clinics and staffing, while communities act early and decisively.

In Sabah, motherhood should not be a gamble shaped by distance and delay.

This is a fight for our future that we can start winning now – one early booking at a time.

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Health Office: Sibu dengue cases down 65 pct in 2025, no deaths recorded

SIBU: Dengue cases in this division dropped by 65 per cent last year, from the figure reported in 2024.

According to Sibu Health Office, a total of 54 dengue cases were recorded last year, down from 153 cases in 2024.

"Out of this (54 cases), Sibu recorded 42 cases, followed by Kanowit with five cases, and Selangau, seven."

Adding on, the Health Office said the nationwide trend also showed a decline in cases.

"Also, the control of cases showed the government's commitment to control dengue via an integrated approach – from innovative vector control to community participation," it said.

It added that there were no reported dengue-related fatalities in the division last year.

Additionally, a total of 302 fogging operations had been carried out in this division last year as part of efforts to combat dengue.

"As for this year, five cases were recorded in the division between Jan 1 and 25, 2026," said the Health Office.

PENYELAMAT TANPA DERIA DENGAR

Golongan OKU digalak belajar CPR, setiap saat amat berharga dalam menentukan hidup dan mati

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Apabila membabitkan rawatan pertolongan cemas untuk menyelamatkan nyawa, setiap saat adalah kritikal dan berharga.

Contohnya 'resusitasi kardiopulmonari' (CPR) adalah prosedur kecemasan yang berpotensi menyelamatkan nyawa seseorang dalam situasi jantung atau pernafasan mereka terhenti.

CPR yang dilakukan dengan mampatan dada pantas (antara 100 hingga 120 kali dalam seminit) di tengah dada boleh membantu mengepam darah beroksigen ke otak dan organ penting.

Bagi individu normal, melakukan CPR kepada individu yang memerlukan mungkin bukan masalah besar.

Tetapi, bagaimana pula dengan komuniti orang kurang upaya (OKU)?

Adakah golongan ini juga sudah diberi pendedahan dan latihan yang secukupnya?

Ini kerana serangan jantung boleh berlaku kepada sesiapa sahaja pada bila-bila masa.

Menyedari keperluan itu, Jabatan Perubatan Kecemasan, Fakulti Perubatan Universiti Kebangsaan Malaysia (UKM) dan Hospital Canselor Tuanku Muhriz (HCTM) menganjurkan program 'Penyelamat Senyap', inisiatif latihan CPR inklusif khusus untuk OKU pendengaran.

BENGKEL latihan CPR dalam bahasa isyarat.

Program itu turut mendapat kerjasama Persatuan Orang Pekak Malaysia (MFD) dan Persatuan Perubatan Islam Malaysia (IMAM).

Timbalan Dekan (Hal Ehwal Jaringan Industri dan Masyarakat) Fakulti Perubatan UKM Prof Madya Dr Ruslinda Mustafar berkata, program itu bertujuan menangani jurang akses latihan kecemasan asas dalam kalangan komuniti pekak yang selama ini berdepan kekangan komunikasi dan ketiadaan modul bersesuaian.

Katanya, melalui pendekatan CPR kaedah 5-T yang digabungkan dengan bahasa isyarat, peserta dilatih kemahiran menyelamatkan nyawa secara lebih mudah, berkesan dan inklusif.

"Tindakan pantas melakukan CPR boleh menyelamatkan nyawa dalam masa beberapa minit sebelum bantuan perubatan tiba.

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