several analyses were done for the primary endpoint.[1] We believe a confusion has arisen between the populations analysed and the management of missing data. Because of more than 10% of missing data for the primary endpoint, a multiple imputation analysis was done, as prespecified in the protocol. This multiple imputation is mandatory in intention-to-treat analyses to avoid attrition bias. Nevertheless, per-protocol analysis does not exclude multiple imputation. The analysis mentioned by Bergeat and colleagues as per protocol is a complete case analysis. The main analysis for the primary endpoint was done on the per-protocol population with multiple imputation; however, three sensitivity analyses were done in addition to the complete case analysis. The conclusion was statistically concordant in favour of non-inferiority of OAGB for all analyses.

Regarding recruitment and El Fara's comment, doing a randomised trial in the field of surgery is difficult because patients must match inclusion criteria, accept the constraints of the study, and be randomly assigned to interventions. However, in the YOMEGA trial,[1] the number of patients included was greater than expected after 12 months, and remained so until the end of the recruitment period. Additionally, our data are open to data sharing, which is an additional guarantee of reliability.

Regarding gastro-oesophageal reflux disease and nutritional complications, in response to Antonio Vitiello and Mario Musella, and El Fara's comments, the development of gastro-oesophageal reflux disease after OAGB ranges between 1% and 4% depending on the studies,[3] but the definition of reflux is unclear and objective data (endoscopy, pH-metry) are still required. Many authors suggest that the frequency of gastro-oesophageal reflux is underestimated because of asymptomatic biliary reflux and the large number of patients lost to follow-up. In the few prospective studies with objective data, development of gastro-oesophageal reflux disease (especially non-acid reflux) appears higher than expected. In the YOMEGA trial,[1] we found a 5·6% frequency of gastro-oesophageal reflux disease in the OAGB group compared with 1·4% in the RYGB group (p>0·05). Contrary to El Fara's comment, all the patients benefited from a preoperative endoscopy as specified in the methods section. The higher rate of oesophagitis found on analysis of biopsies showed that biopsies are necessary to objectively confirm the diagnosis. Even after RYGB, which is known as an anti-reflux technique, Raj and colleagues[4] reported an increase in DeMeester score associated with physiological changes after surgery. Using 24 h impedance-pH-metry, Doulami and colleagues[5] found an increased total number of non-acid reflux episodes after OAGB. The nutritional serious adverse events (21% of the serious adverse events observed in OAGB)[1] were not diagnosed at 2 years, and occurred between 6 and 24 months after surgery. These patients benefited from an adequate nutritional and vitamin supplementation, which probably explains why no difference in biological tests between groups at 2 years was identified.

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Health risks of Rohingya children in Bangladesh: 2 years on

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The Rohingya crisis is a concern for Bangladesh, currently hosting more than 1·1 million Rohingya people who have been subjected to genocide, ethnic cleansing, and systematic discrimination for years in Rakhine, Myanmar.[1] Children make up 55% of the population, and there is little doubt about the magnitude of their health problems.

Prevalence of infectious diseases is high among Rohingya children because of inadequate coverage of vaccination, malnutrition, overcrowding, unsanitary conditions, and lack of access to safe water. Action Against Hunger estimated that 237 500 children aged 6 months to 15 years needed a measles–rubella vaccine.[2] One of the world's largest diphtheria outbreaks happened in early November, 2017, and continued to spread until the outbreak stabilised in mid-2018.[3] The figure provides a summary of crucial epidemic-prone diseases monitored in 2018 and 2019 using data from WHO's Early Warning, Alert and Response System.[4,5] The 2019 statistics indicate that acute respiratory infection and diarrhoea spread in the Rohingya community,

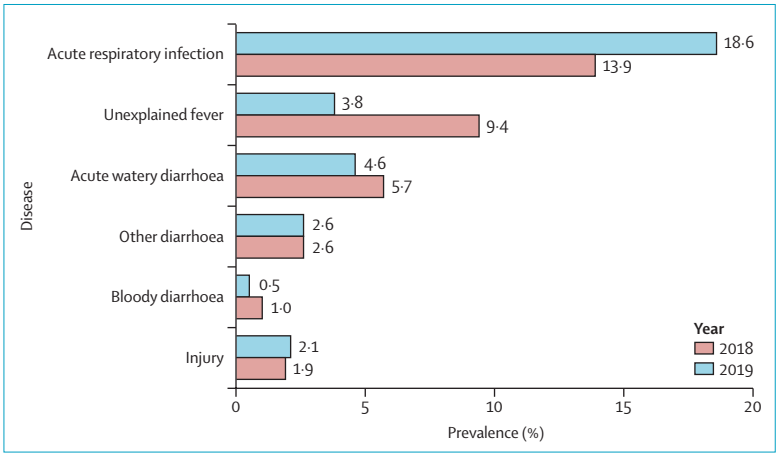

Figure: **Epidemic-prone syndromes and diseases in the Rohingya refugee community reported through WHO's Early Warning, Alert and Response System[4,5]**

making treatment of these common diseases daunting. Moreover, the incidence of water-borne diseases usually rises during the monsoon season.

Despite poor health infrastructure, sensible and systematic efforts by national and international organisations to improve the health of children are making a difference. Between late 2017 and December, 2018, the prevalence of global acute malnutrition in the Rohingya community dropped to 12% from 19%, immunisation coverage increased from less than 3% to 89%, and the proportion of women delivering in health facilities increased from 22% to 40%.[6] However, the prevalence of anaemia in children aged 6–23 months was more than 50%, and stunting among children aged 0–59 months is a serious concern.[6]

The proportion of children in the Rohingya community at pre-primary and primary school level without access to education is approximately 50%, and only 3% of Rohingya adolescents have access to quality education and life-skills training opportunities.[6] Many of the children have mental health problems. According to one report,[7] 52% of Rohingya children have emotional disorders. Traditionally, adolescent girls do not venture out of their homes after reaching puberty and they face violence and human rights abuse, including child marriage.[8] The future is uncertain for Rohingya children, and thus they are in danger of long-term psychological and social distress.

The UN High Commissioner for Refugees population factsheet[1] indicated that as of July 31, 2019, nearly 16% of Rohingya parents raising children are single mothers, and 1% are single fathers. Moreover, 1% of Rohingya child refugees are orphans, and they are the most vulnerable members of the Rohingya community.[1] Rohingya women do not normally seek sexual and reproductive health services and, as a result, many births occur without the assistance of health facilities. Therefore, there is a need for essential reproductive services, along with maternal, child, and newborn health services.

Despite the progress of health outcomes in the last 2 years, Rohingya child refugees face substantial health risks. It is crucial to intensify health services and boost accessibility to essential reproductive health and care for newborns. Prompt action is also necessary to guarantee the satisfactory promotion of health and hygiene to the children and their mothers. Expanded provision of mental health services in the primary health-care system is necessary.

Poor access to health services, a shortage of food, and inadequate shelter are the contemporary challenges, and Rohingya children are suffering the most from these problems. Much more must be done to improve the health of these children before the consequences of living as refugees get worse. Recently, the refugees have refused to return to Rakhine state, demanding guarantees for their safety and citizenship.[9] The future of Rohingya children remains in peril if they stay longer in Bangladesh, and this generation will be condemned to a life in limbo.

We declare no competing interests.

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