## PEER REVIEW HISTORY



## ARTICLE DETAILS

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| **TITLE (PROVISIONAL)** | Child Health CheckPoint: Cohort summary and methodology of a physical health and biospecimen module for the Longitudinal Study of Australian Children |
| **AUTHORS** | Clifford, Susan; Davies, Sarah; Wake, Melissa |

## VERSION 1 - REVIEW

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| **REVIEWER** | Pavel Piler<br>Masaryk University Research Centre for Toxic Compounds in the Environment Czech Republic |
| **REVIEW RETURNED** | 11-Dec-2017 |

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| **GENERAL COMMENTS** | In this paper, the authors introduced and described the biophysical module (the Child Health CheckPoint) related to the ongoing Longitudinal Study of Australian Children (LSAC). The Child Health CheckPoint was a one-off cross-sectional wave of measurements and biological sample collections which enriched the ongoing Longitudinal Study of Australian Children (LSAC) with intergenerational physical health and biomarker data.<br>The main strength of this paper is the well described methodology of all physical measurements and biological samples collection. The paper contains all main characteristics of cohort profile paper such as information about design and aim of the study; inclusion of participants and their basic characteristics; ethical considerations and main strengths and limitations of the study.<br>On the other hand I have some suggestions that the authors should address to increase clarity and appeal of the paper for readers.<br><br>Comments and suggestions:<br>1) I feel that the article title could refer to the fact that the Child Health CkeckPoint is mainly focussed on robust health checks and sample collections.<br>2) Page 3, line 15 + 17. Please, state the exact number of study participants.<br>3) Page 5, lines 43-55 + page 6, lines 3-23. Please, merge those two paragraphs into one with approximately 10 lines.<br>4) Page 6, lines 46, 47: Please, add a table with core phenotypic data group summary.<br>5) Page 7, line 16: Please, omit “In a context of limited funding”<br>6) Page 7, line 23, 26: Please, add citation to “experience suggested” and “attrition”.<br>7) Page 7, line 50: Please, state the exact number of the 3C study participants. |

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| | 8) Page 7, line 56: Please, state the exact number of Victorian families that participated on the recruitment fine-tuning.<br>9) Page 9, line 13: Was setting up a Mini Assessment Centre in a "typical" rural area considered? Balancing the budget and selecting the right study population is typical (and indeed painful) for teams running epidemiologic studies. Expanding the rationale behind selecting or not selecting some groups and/or expanding the article with information how selecting certain groups would have influenced the budget may significantly increase the readers´ interest in this article.<br>10) Page 17, line 57: Please, briefly describe the process of real time quality checks and state their frequency.<br>11) Page 18, line 27: Please, state how long the samples waited for the processing to begin, the time range and median time within which all samples were processed. State the end product of the processing.<br>12) Page 18, line 31: Please, describe in detail the conditions under which the samples were stored before shipping.<br>13) Page 18, line 31: Please, describe in detail the conditions under which the samples were shipped to Melbourne.<br>14) Page 18, line 32: Please, describe in detail the process of sample registration (e.g. 2D, QR code scanning vs manual ID reading), the software you use to catalogue the samples, the time required to transfer the samples from the shipping box to the permanent sample storage. Please, also describe the process of linking the sample with de-identified LSAC data.<br>15) Page 18, Please, add in what environment the samples are permanently stored (-20, -80, -120 and below, nitrogen vapours environment vs. electric freezers), whether you use rapid freezing prior storing the samples. Please, also state whether your sample storage system enables single tube storing/retrieving or you have to take out the whole box of samples in order to pick up one you want.<br>16) Results: Please, add a flowchart which clearly shows number of families invited to the LSAC study (cohort B); number of enrolled families for cohort B; number of retained families for the wave 6, number of families which gave written consent to be contacted by the CheckPoint team, number of families which participated in the CheckPoint wave (Main, Mini, Home option). Please calculate % for each number.<br>17) In the Results, authors included basic characteristics of the LSACCheckPoint participants and non-participants. Could the authors describe main demographic differences between the LSAC, CheckPoint participants, non-participants and the General population?<br>18 In the Results, authors included the Table 3 and Table 4 with numbers of participants for each measure and sample collection. Please could the authors also include the percentages to tables for better transparency?<br>19) Could the authors consider adding one paragraph describing findings from the previous LSAC scientific papers that may benefit from adding the CheckPoint data? Could the authors include some comments on how the new data could enrich current knowledge? |

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| **REVIEWER** | Rubab G. Arim<br>Statistics Canada, Canada |
| **REVIEW RETURNED** | 19-Dec-2017 |

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| **GENERAL COMMENTS** | Growing up in Australia's Child Health CheckPoint cohort summary and methodology<br><br>This paper describes the Child Health CheckPoint, including the methods and sample characteristics. In my opinion, this paper serves as the backbone paper for data users. My comments below are mostly for clarification purposes.<br><br>Abstract<br>Please correct typos in text (e.g. first sentence, delete ' after "Children").<br><br>Given that "parental education were higher and fewer reported non-English speaking or Indigenous backgrounds", representativeness of the sample for the entire Australian population should be discussed.<br><br>Please clarify "different life stages". I think that the authors mean different stages 'during childhood' rather than "different life stages" such as 'childhood and adulthood'?<br><br>Introduction<br>Page 6, lines 23-24. What is known about differences between families who remained in the study compared with those who dropped out? Also, please note that Figure 1 is missing from page 35.<br><br>Methods<br>Page 9, line 12. I assume the research assistant was 'trained'? Please consider adding this information. Also, if all data types of data collection (main, mini, home) were completed by research assistants, this information should be clearly stated. I think it is stated later in text; perhaps it should be moved earlier.<br>Table 1. Hospital admissions and health insurance as well as health service use variables are parent-reported. Are they not captured in administrative data?<br>Page 17, lines 43-45. What percentage of the assessments were completed at home as opposed to assessment centres? Please consider adding this information in brackets.<br>Figure 2. It is unclear which sequence belongs to which visit type. Please consider revising the figure.<br>Page 18, lines 23-24. Please clarify whether the "detailed questionnaire" was about the child (only) or both the child and the parent.<br><br>Results<br>In general, this section appears to be a bit unorganized simply because the reader is not prompted about what to expect in terms of results. Perhaps the authors could add a couple of sentences that provides an overview of their analytical plan. What should the readers expect to find under the results section?<br><br>Discussion<br>Page 26, line 7. Please specify that "parents" are 'mostly mothers'. |

**VERSION 1 – AUTHOR RESPONSE**

| Reviewer Comments | Author's Response | Page, line |
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| Reviewer 1 : Pavel Piler, Masaryk University | | |
| 1. I feel that the article title could refer to the fact that the Child Health CheckPoint is mainly focused on robust health checks and sample collections. | We have updated the paper title to "Child Health CheckPoint: Cohort summary and methodology of a physical health and biospecimen module for the Longitudinal Study of Australian Children". | Page 1, lines 3-6 |
| 2. Page 3, line 15 + 17. Please, state the exact number of study participants. | We now specify the exact number of participants in the abstract:<br>"LSAC recruited a cross-sequential sample of 5107 0-1 and 4983 4-5 year olds in 2004, since completing seven biennial visits." | Page 3, lines 15-16 |
| 3. Page 5, lines 43-55 + page 6, lines 3-23. Please, merge those two paragraphs into one with approximately 10 lines. | We have combined these paragraphs and condensed the information to the minimum detail readers need to be able to understand the cohort study within which our study is embedded. | Page 5, line 42 to<br>page 6, line 30 |
| 4. Page 6, lines 46, 47: Please, add a table with core phenotypic data group summary. | All core phenotypic data are included in Table 1 | No changes were made to the manuscript |
| 5. Page 7, line 16: Please, omit "In a context of limited funding". | We have omitted the text as suggested by the reviewer. | Page 7, line 22 |
| 6. Page 7, line 23, 26: Please, add citation to "experience suggested" and "attrition". | We are not aware of any published research on how children's motivation to participate in research changes with child age, but many longitudinal studies have reduced response during the adolescent years. We have now added citations to the following papers reporting reduced response rates in the ALSPAC, Raine and LSAC cohorts during adolescence:<br>• Boyd A, Golding J, Macleod J, et al. Cohort Profile: the 'children of the 90s'--the index offspring of the Avon Longitudinal Study of Parents and Children. Int J Epidemiol 2013;42(1):111-27.<br>• Straker L, Mountain J, Jacques A, et al. Cohort Profile: The Western Australian Pregnancy Cohort (Raine) Study-Generation 2. Int J Epidemiol 2017;46(5):1384-85j.<br>• Australian Institute of Family Studies. Longitudinal Study of Australian Children Data User Guide - November 2015. Melbourne: Australian Institute of Family Studies, 2015. | Page 7, line 32 |
| 7. Page 7, line 50: Please, state the exact number of the 3C study participants. | We now specify the exact number of participants in the methods text:<br>"…a longitudinal study of 378 7-17 year olds in the MCRI's existing PEAS,[29] LEAP2[30] and HopSCOTCH[31] cohorts… " | Page 7, line 56 |
| 8. Page 7, line 56: Please, state the exact number of Victorian families that participated on the recruitment fine-tuning. | We now specify the exact number of participants in the methods text: | Page 8, line 7 |

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| | | "Late in 2014, we tested the CheckPoint protocol with a vanguard of 52 Victorian LSAC families to fine-tune recruitment…" | |
| 9. | Page 9, line 13: Was setting up a Mini Assessment Centre in a “typical” rural area considered? Balancing the budget and selecting the right study population is typical (and indeed painful) for teams running epidemiologic studies. Expanding the rationale behind selecting or not selecting some groups and/or expanding the article with information how selecting certain groups would have influenced the budget may significantly increase the readers´ interest in this article. | The CheckPoint team did not select the study sample; it had already been recruited by LSAC a decade prior. LSAC's original sampling frame was a two-staged clustered design, first selecting postcodes, then resident children within those postcodes. As a result, the rural participants are not evenly distributed throughout the country, but clustered in and around rural cities and townships.<br><br>Table 2 shows a similar geographic distribution between CheckPoint participants and non-responders.<br><br>We have expanded the methods text to now read:<br>"In total, the study visited over 30 cities and towns over the one-year data collection period (supplementary figure 1). The Assessment Centre operated in 15 cities and towns. This number was constrained by the fixed data collection window and budget (i.e. substantial time and costs of setting up in each location, regardless of the number of participants seen). The specific locations chosen were the cities and towns with the largest clusters of B cohort participants. Using mapping software, we plotted participants residing within 2 hours travel radius of each regional city. If the regional city had the necessary infrastructure for a Mini Assessment centre and at least 40 eligible families within the radius, we set up a centre; otherwise we offered Home Visits. | Page 9, lines 35-48 |
| 10. | Page 17, line 57: Please, briefly describe the process of real time quality checks and state their frequency. | We have expanded the methods text to now read:<br>"Research assistants and students were trained by experts, and real-time quality checks were undertaken throughout the data collection period. These checks included data range checks integrated into the data entry forms; dynamic data completeness checks for each participant during and at the end of their visit, with gaps redressed by a dedicated staff member before departure; weekly completeness checks for the study overall and ongoing process modifications to address all causes of missing data identified; random visual checks of the data to identify and fix any developing departures from protocol; and ongoing staff training, time trials and testing knowledge of Standard Operating Procedures." | Page 18, line 53 to<br>page 19, line 13 |
| 11. | Page 18, line 27: Please, state how long the samples waited for the processing to begin, the time range and median time within which all samples were processed. State the end product of the processing. | We have added information about biosample processing times, and a citation to the CheckPoint Data Issues technical paper which discusses urine processing time in greater detail. This paper is in final draft mode and we expect to upload it onto the study website in the next month. We attach the Data Issues paper draft for the reviewer's reference. | Page 19, lines 43-49 |

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| | | We have updated the methods text to now read:<br>"Samples (except buccal swabs) were processed within hours in an on-site laboratory set up at all Main Assessment and most Mini Assessment Centres. Blood and saliva samples were generally processed within an hour (blood: range 1 minute to 3.8 hours, median 53 minutes; saliva: range 1 minute to 5.7 hours, median 44 minutes). Urine sample processing was delayed if collected away from a laboratory; 56% of urine samples processed within three hours (range 1 minute to 9 days, median 71 minutes).REF1"<br><br>REF1 = Davies S, Clifford SA, Gillespie A, et al. LSAC's Child Health CheckPoint Data Issues Paper 2017. Melbourne, Australia: Murdoch Children's Research Institute, 2017.<br><br>The end product of the processing is described for each sample type in Table 1 (most right-hand column. | |
| 12. | Page 18, line 31: Please, describe in detail the conditions under which the samples were stored before shipping. | Liquid samples and blood clots were stored on site at -80$^{\mu}$C and the remaining samples at room temperature. This information is provided for each sample in Table 1 (most right-hand column). | No changes were made to the manuscript |
| 13. | Page 18, line 31: Please, describe in detail the conditions under which the samples were shipped to Melbourne. | We have updated the methods text to now read:<br>"At the completion of each Assessment Centre, a single batch of all frozen samples were shipped on dry ice to the Melbourne Children's Bioresource Centre (at the MCRI) for long term storage at -80$^{\circ}$C (except buffy coat aliquots are stored in vapour phase liquid nitrogen). A temperature data logger was included in each shipment to confirm optimal temperature throughout. All other samples, kept at room temperature, were transported at the same time." | Page 19, line 49 to<br>page 20, line 5 |
| 14. | Page 18, line 32: Please, describe in detail the process of sample registration (e.g. 2D, QR code scanning vs manual ID reading), the software you use to catalogue the samples, the time required to transfer the samples from the shipping box to the permanent sample storage. Please, also describe the process of linking the sample with de-identified LSAC data. | We have updated the methods text to now read:<br>"Samples were tracked using QR code scanners and FreezerPro Enterprise (RuRo, Maryland, USA) software."<br><br>We did not record how long it took to transfer the samples from the shipping box to the freezer, but estimate it took a few minutes to empty a shipping box.<br><br>We have updated the methods text to now read:<br>"All samples are stored in a de-identified manner and are only identified for extraction from the repository. Newly derived biospecimen data is linked to the participant by an external staff member using a linkage key". | Page 20, lines 5-11 |
| 15. | Page 18, Please, add in what environment the samples are permanently stored (-20, -80, -120 and below, nitrogen vapours | We have updated the methods text to now read:<br>"At the completion of each Assessment Centre, a single batch of all frozen samples were shipped on dry ice to the Melbourne Children's Bioresource Centre (at the | Page 19, line 49 to<br>page 20, line 13 |

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| | environment vs. electric freezers), whether you use rapid freezing prior storing the samples. Please, also state whether your sample storage system enables single tube storing/retrieving or you have to take out the whole box of samples in order to pick up one you want. | MCRI) for long term storage at -80◦C (except buffy coat aliquots are stored in vapour phase liquid nitrogen). A temperature data logger was included in each shipment to confirm optimal temperature throughout. All other samples, kept at room temperature, were transported at the same time. All samples are stored in a de-identified manner and are only identified for extraction from the repository. Newly derived biospecimen data is linked to the participant by an external staff member using a linkage key. Samples were tracked using QR code scanners and FreezerPro Enterprise (RuRo, Maryland, USA) software. Frozen samples are stored in boxes of 96 aliquots, and aliquot picking is undertaken by hand (i.e. not automated by robot)."<br><br>We have updated the Table 1 text for 'venous blood' to specify freezing conditions for buffy coat different from the other blood fractions:<br>"All serum, plasma and clot samples frozen directly at -80◦C on site, while buffy coat aliquots were prepared in a freeze mix (10% fetal bovine serum + 10% DMSO in BME) and placed within CoolCells (Biotools, Australia) prior to control the rate of freezing at -80◦C to maximize cell viability." | |
| 16. | Results: Please, add a flowchart which clearly shows number of families invited to the LSAC study (cohort B); number of enrolled families for cohort B; number of retained families for the wave 6, number of families which gave written consent to be contacted by the CheckPoint team, number of families which participated in the CheckPoint wave (Main, Mini, Home option). Please calculate % for each number. | Unfortunately the participant flow chart (Figure 1) did not display in the combined PDF provided to reviewers. We have compressed the file size of this image and include the updated file as part of this revision. | Figure 1 |
| 17. | In the Results, authors included basic characteristics of the LSAC CheckPoint participants and non-participants. Could the authors describe main demographic differences between the LSAC, CheckPoint participants, non-participants and the General population? | As the reviewer notes, we have described in Table 2 how CheckPoint participants differ from LSAC participants, and in the text on page 22 how the CheckPoint participants differ from the Australian population. The last remaining possible combination – how LSAC participants differs from the Australian population – has recently been comprehensively described by Cusack 2013 and Edwards 2014.<br><br>We have added a sentence and citations to these papers to the methods section:<br>"The majority of CheckPoint families lived in major cities, with a similar distribution across the states and territories | Page 22, lines 6-13<br><br>Page 6, lines 24-29 |

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| | | to the Australian population. Larger proportions of families were in the higher socio-economic position quintiles than in the Australian population. Detailed comparisons of the LSAC sample to the Australian population have been published previously [REF1,2]"<br><br>We have also added the following text to the Introduction (page 6), in response to Reviewer 2's fourth comment: "At wave 6 (child age 10-11), 74% of the original B cohort were retained; families with Indigenous or non-English speaking backgrounds, or incomes less than $1000 per week were under-represented in later waves.[REF1]"<br><br>REF1= Cusack B, Defina R. LSAC technical paper number 10: Wave 5 weighting and non response. Melbourne: Australian Institute of Family Studies, 2013.<br>REF2= Edwards B. Growing Up in Australia: The Longitudinal Study of Australian Children Entering adolescence and becoming a young adult. Family Matters 2014;95:5-14. | |
| 18. | In the Results, authors included the Table 3 and Table 4 with numbers of participants for each measure and sample collection. Please could the authors also include the percentages to tables for better transparency? | We have updated the tables to show n (%) in each cell. | Table 3, pages 25-26<br>Table 4, page 28 |
| 19. | Could the authors consider adding one paragraph describing findings from the previous LSAC scientific papers that may benefit from adding the CheckPoint data? Could the authors include some comments on how the new data could enrich current knowledge? | We have included the following additional paragraph to the discussion:<br>In the study's first decade, over 500 papers have been published using LSAC data. Child health is one of the most common topics of LSAC papers,[REF1] and many of these health-related research questions could be extended upon now that the CheckPoint data are available. For example, research papers on the parent-reported health comorbidities of overweight[REF2] or short sleep duration[REF3] published by our group could be extended to include comprehensive objective measures of segmental body composition, 24-hour time use including sleep and a range of health outcomes (e.g. serum blood parameters, arterial structure and function). The greater precision brought by using these measures may reveal nuances in the associations not detectable using reported measures. Many new health-related questions are also now able to be examined, as LSAC's broad range of early life exposures are reflected in peripubertal metabolic health and development of a wide range of body systems. In addition, the CheckPoint dataset will be augmented with genetic data in late 2019, which will facilitate gene-environment analyses for the first time in this cohort." | Page 30, lines 36-56 |

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| | REF1= Edwards B. Growing Up in Australia: The Longitudinal Study of Australian Children Entering adolescence and becoming a young adult. Family Matters 2014;95:5-14.<br>REF2= Wake M, Clifford SA, Patton GC, et al. Morbidity patterns among the underweight, overweight and obese between 2 and 18 years: population-based cross-sectional analyses. Int J Obes (Lond) 2013;37(1):86-93.<br>REF3= Price AMH, Quach J, Wake M, et al. Cross-sectional sleep thresholds for optimal health and well-being in Australian 4-9-year-olds. Sleep Med 2016;22:83-90. | |
| Reviewer 2: Rubab G. Arim, Statistics Canada | | |
| 1. Abstract: Please correct typos in text (e.g. first sentence, delete ‘ after “Children”). | We intentionally inserted quotation marks around the full name of the study, to improve readability of the sentence. However, we are happy to remove these quotation marks if you think this is clearer. | No change to manuscript |
| 2. Abstract: Given that “parental education were higher and fewer reported non-English speaking or Indigenous backgrounds”, representativeness of the sample for the entire Australian population should be discussed. | The original abstract text was:<br>"Participants' geographical distribution mirrored the broader Australian population; however, mean socioeconomic position and parental education were higher and fewer reported non-English speaking or Indigenous backgrounds."<br>We have added another sentence:<br>"Application of survey weights partially mitigates that the achieved sample is less population-representative than previous waves of LSAC due to non-random attrition." | Page 3, lines 42-45 |
| 3. Abstract: Please clarify “different life stages”. I think that the authors mean different stages ‘during childhood’ rather than “different life stages” such as ‘childhood and adulthood’? | We mean the later, specifically childhood and mid-adulthood.<br>We have updated the abstract to read:<br>"CheckPoint enriches LSAC to study how NCDs develop at the molecular and phenotypic levels before overt disease emerges, and clarify the underlying dimensionality of health in childhood and mid-adulthood." | Page 3, line 54 |
| 4. Introduction: Page 6, lines 23-24. What is known about differences between families who remained in the study compared with those who dropped out? Also, please note that Figure 1 is missing from page 35. | We have added the following text to the Introduction:<br>"At wave 6 (child age 10-11), 74% of the original B cohort were retained; families with Indigenous or non-English speaking backgrounds, or incomes less than $1000 per week were under-represented in later waves.[REF1]"<br><br>REF1= Cusack B, Defina R. LSAC technical paper number 10: Wave 5 weighting and non response. Melbourne: Australian Institute of Family Studies, 2013.<br><br>Unfortunately the submitted participant flow chart (Figure 1) did not display in the combined PDF provided to reviewers. We have compressed the file size of this image and include the updated file as part of this revision. | Page 6, lines 24-29 |

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| 5. | Methods: Page 9, line 12. I assume the research assistant was 'trained'? Please consider adding this information. Also, if all data types of data collection (main, mini, home) were completed by research assistants, this information should be clearly stated. I think it is stated later in text; perhaps it should be moved earlier. | We have updated the text to read:<br>"Those unable to attend an assessment centre were offered a 1½-hour home visit with a subset of measures that could be conducted in the home by a trained research assistant (ie not a phlebotomist) using portable equipment."<br>We have moved the text specifying assessments were undertaken by research assistants and students to earlier in the methods section:<br>"Assessments and phone interviews were conducted by trained research assistants and students." | Page 9, line 28<br><br>page 8, lines 55-57 |
| 6. | Methods: Table 1. Hospital admissions and health insurance as well as health service use variables are parent-reported. Are they not captured in administrative data? | Unfortunately, we need to use parent-reported data as comprehensive Australian hospitalisations and health service use administrative data are not available for research purposes for privacy reasons. The LSAC (not CheckPoint) dataset does contain administrative data for primary healthcare and most medications prescriptions filled, but these datasets do not include hospital-based and specialist healthcare, or medication prescriptions which are fully paid by the patient (i.e. not co-paid by the government) or not dispensed. | No changes were made to the manuscript |
| 7. | Methods: Page 17, lines 43-45. What percentage of the assessments were completed at home as opposed to assessment centres? Please consider adding this information in brackets. | We have specified the proportion of participants receiving a home visit to the methods section, where we first introduce the three visit types:<br>"Most families (72%) attended a Main Assessment Centre, 8% attended a Mini Assessment Centre and 20% completed a home visit."<br>This information is also included in Figure 1. | Page 9, lines 47-49 |
| 8. | Methods: Figure 2. It is unclear which sequence belongs to which visit type. Please consider revising the figure. | The figure has the subheadings 'Main Assessment Centre', 'Mini Assessment Centre' and 'Home Visits' in black text above each of the three assessment sequences. Unfortunately this text was not visible in the combined PDF sent to reviewers. We have saved this image in a different file format and include the updated file as part of this revision. | Figure 2 |
| 9. | Methods: Page 18, lines 23-24. Please clarify whether the "detailed questionnaire" was about the child (only) or both the child and the parent. | We have updated the methods text to now read:<br>"Most measures were offered to both children and parents; however, the parent flow omitted the exercise stations (Bike Hike and Jumping Beans), time-use diary, post-bronchodilator spirometry and toenail samples. Instead, parents completed a more detailed questionnaire about their child's healthcare (including hospitalisations), medications and use of community services; and their own health-related quality of life." | Page 19, lines 33-38 |
| 10. | Results: In general, this section appears to be a bit unorganized simply because the reader is not prompted about what to expect in terms of results. Perhaps the authors could add a couple of sentences that provides an | We thank the reviewer for this helpful suggestion. We have added the following text to the beginning of the results section:<br>"Below we summarise the vanguard participants' evaluation of the CheckPoint module. We then describe B cohort recruitment and reasons for non-participation in the CheckPoint module, and demographic characteristics | Page 21, lines 14-20 |

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| | overview of their analytical plan. What should the readers expect to find under the results section? | of CheckPoint participants and non-responders. Lastly, we summarise data completeness for each measure, and biospecimen collection and consent rates." | |
| 11. | Discussion: Page 26, line 7. Please specify that “parents” are ‘mostly mothers’. | We have updated the discussion text to now read: "The Child Health CheckPoint provides a paired cross-generational snapshot of the health of 11-12 year old Australian children and their parents who took part in the CheckPoint assessment (mostly mothers)." | Page 29, lines 7-8 |