PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Women and Substance Use: A qualitative study on sexual and reproductive health of women who use drugs in Delhi, India
AUTHORS	Sharma, Vartika; Sarna, Avina; Tun, Waimar; Saraswati, Lopamudra Ray; Thior, Ibou; Madan, Ira; Luchters, Stanley

VERSION 1 – REVIEW

REVIEWER	Enisha sarin Independent consultant India
REVIEW RETURNED	03-Aug-2017

GENERAL COMMENTS	No local ethical review was included. This is problematic as the study population is vulnerable and have been always available for research purposes without any constructive intervention been provided to them for so many years. Perhaps a sentence about why a local ethical review was not felt to be necessary will help. The authors recommend a one stop shop which is a useful intervention to have for female drug users. But there was no detail about how to make it accessible to the women. The need for outreach among this population is a constant and should be included.. The study findings could have been obtained through a quantitative survey too, as there was not much nuance or depth in the results section. i hope the authors got enough information and would be able to delve in the future into the inter- connection of poverty, drug market, need for survival of self and offspring, and the psychological aspects/ramifications of neglect of child care.

REVIEWER	Sana Shahram Centre for Addictions Research of BC, University of Victoria, Canada
REVIEW RETURNED	09-Aug-2017

GENERAL COMMENTS	This paper's objective is to contextualize the poor sexual and reproductive risks experienced by women who use drugs in Delhi, India. This is an important topic that can contribute to the research landscape. The paper contains many typos and grammatical errors and would benefit greatly from review and re-writing. For example, a repeated error with the usage of "few women" makes it challenging to understand what the authors mean, where I assume their meaning is that "a few" or "some" women.

	Issues with written English are throughout the paper and make it cumbersome to read. The objective of the study is worded in a way that is confusing. "Enhancing vulnerabilities" is an unclear concept, since "enhance" usually implies increasing something positively. The objective, as well as the entire paper, would benefit from more strengths-based writing and a focus on supporting the health of women in the study, rather than reinforcing the idea that vulnerabilities and risks are embodied by the women themselves. For example, the authors mention women's "decision-making skills" are impaired due to drug use. However, given that they are trying to explain context, it would be much more appropriate to acknowledge the constraints under which women are making their decisions, rather than to attribute it solely to their own lack of decision making skills. Further to this, the concept of "risk profiles" is dehumanizing and has very little to do with context. The way this paper is currently written does not seem to add much to the literature in terms of new understandings, and instead seems to perpetuate several prevalent misrepresentations of women who use drugs. The entire paper would benefit from a more explicit acknowledgement of the contexts of women's lives, and how that impacts their health and well-being. As it is currently written, issues like violence, trauma, stigma are given only cursory attention as a means to describe the outcomes the authors think are important. However, those contexts are the real value of this work and should be brought to the forefront. Other feedback: INTRODUCTION - There is very little context or background that is specific to women who use drugs in Delhi. The reader would benefit from knowing how women who use drugs in this area are treated, social and cultural taboos etc. to allow them to fully understand women's experiences. - Please see points at beginning of the review re: unclear objectives, "decision-making skills" and "risk profiles" ETHICS - The authors only got ethical review from USA-based review boards. With this type of research and this type of population, I think it would be wholly appropriate to get some type of ethics review or oversight from a more local agency, organization, or community group. This seems to be an oversight and/or warrants further explanation. METHODS - Why would the women who are already participating in the larger study get less money for the exact same work and contribution the other women provided? The compensation is meant to compensate them for their contribution, so this seems very paternalistic and arbitrary. - How was the compensation amount decided upon? Through consultation with whom? - The methods section in general does not contain enough detail. The authors mention "Qualitative interviews" which is not descriptive of a specific method. What types of interviews were conducted? Semi-structured? Based on what theoretical approach? Who decided which topics were important? Based on what previous research/knowledge with this population? - The description of the analysis does not provide enough detail for review.

	The authors mention content analysis...is this what they mean? This analysis needs to be situated and described in more detail as there are several approaches to content analysis that involve very different steps, none of which are described in enough detail. The use of references here would be highly beneficial. RESULTS - The tense/wording in the demographics table is confusing ex. "lived on street"...and the columns don't appear to be lined up which makes it challenging to read. - There is a note that only women who were married were asked about their children, however since no context of the situation for women in Delhi is provided, it is unclear why this was. If it was taboo to ask, this needs to be explained. - The job descriptions included with women's pseudonym's seem highly stigmatizing (ex. "beggar", "pick-pocketer") and I'm confused why these specifically were used to add context to women's lives? In addition, according to the demographics table, it appears some women had multiple sources of income, so it is not clear how you decided to identify their singular profession for the quotes. Perhaps something else could be used that could both contextualize women's lives and further humanize/empower their voices? - Some of the quotes do not seem to illustrate the points made by the authors. For example, the authors' claim sex work gave some women "self-assurance or independence" but the quote following this does not convey this message. Perhaps more of the quote needs to be included, or the authors need to revise their understanding of the quote? - In the section of violence, suicide (self-harm) and violence (from external sources) are confounded into one. This seems inappropriate, and the quotes provided only depict women's stories of self-harm. Further, although this was meant to contextualize women's lives, there is very little context in terms of women's childhood experiences and environments which are also important. - The results are very long, disjointed and repetitive. For example, condom usage is discussed in multiple areas under multiple subheadings. The results would benefit from being much more concise, and more clearly organized so that the reader can follow along. In addition, the results are categorized in some parts according to women's contexts and in other parts according to "vulnerabilities"...it seems that it would make a lot more sense to organize according to the "risk/vulnerability" and then within that section contextualize WHY that risk exists, with more information than just the behaviour women partake in. - Forced sex is included in "high risk sexual acts", instead of being classified as violence, assault or rape. This is highly problematic as it suggests this is a behaviour a woman is actively engaging in, instead of something she is a victim of. This is also why "risk profiles" are problematic as they embody the risk within the women, instead of rightfully on the systems, structures and processes that lead to them being exposed to high risk environments. Critical engagement with these issues would be highly beneficial and necessary to this paper and work as a whole before it could be considered publishable. -The results seem to focus mostly on women's behaviours, rather than the context of WHY these behaviours are occurring. Re-framing the results to be more explicitly about the actual context is important not only for clarity, but for doing due diligence to women's lives, strengths, and their own visions for their health and well-being. - The authors talk about women's "unmet needs" for health care.

	As is true throughout the results, it is unclear if this is the assessment of the authors or if women themselves consider their health care needs unmet. Similarly, the authors say women "ignored symptoms of poor reproductive health"...is this the authors' assessment or what women said? It would seem from the quotes that women are not ignoring symptoms, so much as that they don't have the education, resources or skills to do anything about them, which is a very different issue. Clarification is needed. - "women gave limited importance to their healthcare needs" is again confusing as this seems to be the author's judgement/statement that is not backed up by any data. What seems more clear from this data is that women lack access to the right services, not that they don't care about their health. Similarly, the idea of stigma, and poor encounters with health care workers and systems is clearly evident in the data but is not given much attention by the authors...this is a very important context to why women may be experiencing poor sexual and reproductive health outcomes. DISCUSSION The discussion can be strengthened and focused once the above revisions are addressed. SUMMARY I am not sure if a major revision can address the fundamental problems with this paper, as it may have required different questions to have been asked, or for the data to have been re-coded. However, since women participated in this study, presumably for the purpose of improving the services they receive in some way or contributing to something of import to themselves (although, again, this would need to be explained somewhere), I feel these revisions are important and necessary regardless of where/if the paper is published. Thank you to the authors for the effort in conducting this work and writing and submitting this paper. I hope that this feedback will prove helpful in improving this work and accomplishing yours and the participants' ultimate goals.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1

Q. No local ethical review was included. This is problematic as the study population is vulnerable and have been always available for research purposes without any constructive intervention been provided to them for so many years. Perhaps a sentence about why a local ethical review was not felt to be necessary will help.

Response: The authors understand the reviewer's concern and wish to clarify that the women who injected drugs were enrolled under the HIV sero-incidence cohort study. This study was approved by the local ethical review by Technical Resource Group and Ethics Committee of National AIDS Control Organization, Government of India. It was additionally approved by Population Council Institutional Review Board (USA) and PATH Research Ethics Committee (USA).
The targeted outreach conducted as a part of the HIV sero-incidence study indicated that women were more likely to use drugs through non-injecting routes. Therefore, to complement the parent cohort study, women/NI were recruited for the qualitative study.

The qualitative study presented in the manuscript was based on one-time data collection and did not include any biological sample collection. Therefore, IRB approvals were only taken from the ethical committees of implementing research agency (Population Council) and donor agency (PATH) who were involved in regular monitoring of the study.

To ensure that all research work was done as per the international standards of research ethics and interests of the community were safeguarded, all researchers and research interviewers were mandated to complete a certification course in research ethics before the study was initiated. Furthermore, all activities and procedures were planned and implemented in partnership with the local NGO which had extensively worked with this population and thus ensured the appropriateness of the study procedures and protocols for the community.

Q. The authors recommend a one stop shop which is a useful intervention to have for female drug users. But there was no detail about how to make it accessible to the women. The need for outreach among this population is a constant and should be included.

Response: As advised by the reviewer, we have revised the discussion section of the manuscript to recommend expansion of community-based facility such as a drop-in-center to provide comprehensive package of services including reproductive health services and drug dependence treatment services for all women who use drugs. This has been suggested keeping in mind that most women had household responsibilities especially children to take care of and hence long -term institutional care may be difficult for them.

Q. The study findings could have been obtained through a quantitative survey too, as there was not much nuance or depth in the results section.

Response: As advised, we have restructured the results section to illustrate the contextual understanding of the behaviors and needs being discussed. For example, we've expanded on participant's discussions of the role of unsteady relationship in determining their SRH-related health needs, marital conflicts related to drug use, multiple sex partners of their regular partners, coercion to have a child to satisfy the wishes of their new partners etc. Further, we discuss social stigma (for both drug use and sex-work) and how it explains the context in which women constantly lead insecure lives with obvious repercussions on their behaviours and needs.

The authors would like to highlight some examples of sensitive contextual information obtained through qualitative study design:
1. The quotes illustrating women's feelings of anger, disgust and helplessness regarding some of the sexual practices helped the authors to differentiate between mutual sex behaviors and sexual violence inflicted on them. The quote that 'he forced himself in my mouth' clearly indicate that it was against the consent of the women.
2. Considering the skewed gender power dynamics, men often engage in multiple partnerships without giving much consideration to the consequences. However, quote from a participant where she mentioned 'that I left my husband and came to Delhi with my children' showed a strong sense of agency in decision-making.
3. Various studies have reported reluctance on part of men in using condoms but the quotes from participants such as – 'forgot to use condom under influence of drugs' or 'too drugged to even realize when she has intercourse' or 'expecting the client to bring the condom', is suggestive of need to continue the focus of intervention on women (of course, in addition to men) to make them practice safer behavior.

Information on their own discretion on unprotected sex such as clean looking men vs. unclean men, alcohol drinking vs. injection using clients are findings possible through qualitative data collection
4. Some of the reasons for violence shared by the participant may be similar to the general population, but some were completely related to their drug use behavior – such as a partner trying to get them off drugs, violence due to inability to take care of household chores due to drug use and mention of self-inflicted injuries. Sexual violence at the hands of policemen was a sensitive information considering they are the custodians of law.
5. Some of the quotes clearly manifest feelings of self-stigma which can be a major deterrent in accessing healthcare services – 'everyone knows women who use drugs have such problems in conceiving', 'since I use smack how will I or where will I get treatment'.

Q. I hope the authors got enough information and would be able to delve in the future into the inter-connection of poverty, drug market, need for survival of self and offspring, and the psychological aspects/ramifications of neglect of child care.

Response: The study findings have briefly discussed the financial challenges (for example, engaging in sex work to support drug use or child-rearing and consequent effect on SRH-related outcomes). The authors acknowledge the potential impact of structural issues such as poverty and 'child-centric responsibilities' on women's access to services especially if it needs some in-patient care. However, considering the objective of this study was to focus on SRH specific issues, we could not explore issues around survival and psychological aspects of neglected child care.

Reviewer 2
Q. The paper contains many typos and grammatical errors and would benefit greatly from review and re-writing. For example, a repeated error with the usage of "few women" makes it challenging to understand what the authors mean, where I assume their meaning is that "a few" or "some" women. Issues with written English are throughout the paper and make it cumbersome to read.

Response: The authors have used the assistance of a native English speaking colleague in the United States to review the language of the manuscript. We sincerely hope that the reviewers will find the revised version of the manuscript without any grammatical errors.

Q. The objective of the study is worded in a way that is confusing. "Enhancing vulnerabilities" is an unclear concept, since "enhance" usually implies increasing something positively.
Response: As noted by the reviewer, we acknowledge the error and have corrected it to state 'increased vulnerability'.

Q. The objective, as well as the entire paper, would benefit from more strengths-based writing and a focus on supporting the health of women in the study, rather than reinforcing the idea that vulnerabilities and risks are embodied by the women themselves. For example, the authors mention women's "decision-making skills" are impaired due to drug use. However, given that they are trying to explain context, it would be much more appropriate to acknowledge the constraints under which women are making their decisions, rather than to attribute it solely to their own lack of decision making skills.

Response: As advised by the reviewer, the authors have restructured the manuscript wherein now decisions/behaviors/needs have been explained with reference to underlying individual and socio-cultural context which influence them. We have re-read the interviews to pull out quotes which strengthen the data findings. Further, the language used in the manuscript has been suitably modified to ensure that behaviors and needs are suitably linked to the context rather than assuming or expecting the reader to understand those related concepts.

Q. Further to this, the concept of "risk profiles" is dehumanizing and has very little to do with context.

Response: The authors have duly-noted the reviewer's observation and the term 'risk profile' has been suitably amended to reflect that recruitment in the qualitative study was stopped once data saturation was achieved; i.e. no new behaviors/needs/contextual factors were reported.

Q. The way this paper is currently written does not seem to add much to the literature in terms of new understandings, and instead seems to perpetuate several prevalent misrepresentations of women who use drugs.

Response: The authors have amended the background section to reflect the following facts which support the reason for conducting this qualitative study with women who use drugs in Delhi.
1. Considering that women who use drugs is a relatively small population in India, there is very limited focus and hence limited evidence related to them.
2. In India, the existing evidence is largely focused on women who inject drugs (since they are one of the high-risk groups identified under the HIV/AIDS control program in India) but not much on women who use drugs through non-injecting routes. Thus, this paper provides evidence of the behavior and needs of this population.
3. Most of evidence on women who use drugs is based out of north-eastern states of Manipur and Nagaland, which are distinct from the rest of the country in multiple ways as explained in the manuscript.
Therefore, to the best of our knowledge, this is the first study to explore the SRH- related needs (beyond HIV) of women who use drugs in Delhi, along with the contextual factors that shape these behaviors.
As mentioned above, we have restructured and rewritten the results section to incorporate correct representations of views expressed by the participants, appropriately supported by the quotes from them.

Q. The entire paper would benefit from a more explicit acknowledgement of the contexts of women's lives, and how that impacts their health and well-being.

Response: The authors have restructured the results section and now present the context of specific behaviors/needs/decisions identified from the interviews. The discussion section brings together the complex interplay of factors at individual, family, community and institutional level, all of which significantly shape women's behaviors and needs.

Q. As it is currently written, issues like violence, trauma, stigma are given only cursory attention as a means to describe the outcomes the authors think are important. However, those contexts are the real value of this work and should be brought to the forefront.

Response: The authors would like to clarify that violence was a subject that women spoke about at various times during the interviews - in context to their relationship with regular partners, sex work and by their peers since many of them lived and used drugs on the streets. In the restructured results section, we have strengthened study findings by including some more information on role of violence and stigma in context of their own risk assessment and access to healthcare, role in decision-making with partners and negotiation for safe sex with clients of sex work. We have also strengthened the discussion section to highlight other studies which demonstrate the adverse impact of intimate partner violence on SRH outcomes of women.

Q. There is very little context or background that is specific to women who use drugs in Delhi. The reader would benefit from knowing how women who use drugs in this area are treated, social and cultural taboos etc. to allow them to fully understand women's experiences.

Response: Across India, compared to men who use drugs, women have received limited attention since they constitute a small proportion of the drug using population in India. In India, the research work on WUD has been limited to the two north-eastern states of India - Manipur and Nagaland. Both states are ethnically and culturally distinct, geographically isolated from the rest of India, and are characterized by substantial under-development compared to other states.
They share a long porous border with Myanmar, one of the world's largest producers of heroin, and thus availability of drugs for illegal drug use is very common. These states are often characterized by various long-standing civil insurgent movements, deeply felt social conservatism, and substantial under-development. Manipur and Nagaland have one of the highest HIV prevalence in India, and unsafe injecting drug use has made a major contribution to the HIV epidemic in this region. Delhi, on the other hand has recently been identified as a state with emerging injection drug use problem. Unlike Manipur and Nagaland, the socio-political environment in Delhi is stable and the HIV epidemic is still largely fueled by heterosexual transmission. Considering these contextual differences, there is merit in understanding the risk behaviors and needs of women who use drugs in Delhi.
Further, the existing research studies based in Delhi have largely been with men who inject drugs. One large study with people who inject drugs (PWID) in 26 cities in India included Delhi , however the female participants were almost exclusively recruited from study sites in the north-eastern region of the country, thereby not reflecting the status of women who inject drugs in Delhi. Another study by Kermode et al. with women who use alcohol and drugs in the north-eastern states of Manipur and Nagaland identified their health problems and other issues such as social exclusion, violence etc. but considering it was a qualitative investigation, authors had cautioned against generalizability of study findings even among this population based out of Manipur and Nagaland. In the north-eastern states, the research has been focused on female sex workers who use drugs through non-injecting route, but the context of those studies was entirely different. Reference of both these studies has been included in the background section of the revised manuscript.
Therefore, to the best of our knowledge, this is the first study which attempts to understand the SRH related behaviors (beyond HIV), needs and the context in which women who use drugs make certain behavior choices.

Q. Please see points at beginning of the review re: unclear objectives, "decision-making skills" and "risk profiles"

Response: The discussion section has been appropriately amended to explain why the decision-making skills may have adverse SRH outcomes by using the 'theory of reasoned action'. The authors have also duly-noted the reviewer's observation and the term of 'risk profile' has been suitably amended to reflect that recruitment in the qualitative study was stopped once data saturation was achieved; i.e. no new behaviors/needs/contextual factors were reported.

Q.The authors only got ethical review from USA-based review boards. With this type of research and this type of population, I think it would be wholly appropriate to get some type of ethics review or oversight from a more local agency, organization, or community group. This seems to be an oversight and/or warrants further explanation.

Response: Please see response to Reviewer #1

Q. Why would the women who are already participating in the larger study get less money for the exact same work and contribution the other women provided? The compensation is meant to compensate them for their contribution, so this seems very paternalistic and arbitrary.

Response: Women/I received slightly lower compensation (USD 1.50) compared to women/NI (USD 2.20) since visits to the DICs by the former group were part of their participation in the HIV sero-incidence study (the parent study) and hence they received compensation only for their time spent for the study (informed consent and in-depth interview). However, the latter group visited the DIC specifically for participating in the interview and thus were compensated for both - their time for spent in interview and travel to the DIC. This information has also been clarified in the revised manuscript.

Q. How was the compensation amount decided upon? Through consultation with whom?

Response: The compensation was decided basis our discussions with the NGO partner – Sahara Center for Residential Care and Rehabilitation. The opportunity cost for the time spent in travel and in participation in the study was used to decide the compensation amount.

Q. The methods section in general does not contain enough detail. The authors mention "Qualitative interviews" which is not descriptive of a specific method. What types of interviews were conducted? Semi-structured? Based on what theoretical approach? Who decided which topics were important? Based on what previous research/knowledge with this population?

Response: The authors have strengthened the methods section with details on the study design and analytical approach used. The revised manuscript now reflects that semi-structured interview guide was used to conduct the in-depth interviews.
An interpretivist approach, using the social-constructivist theory (Berger and Luckmann, 1966) was used to understand how certain negative SRH- related outcomes are embedded with cultural meaning, and are socially constructed at an experiential level, based on how individuals come to understand and live with their negative health conditions.

Q. The description of the analysis does not provide enough detail for review. The authors mention content analysis...is this what they mean? This analysis needs to be situated and described in more detail as there are several approaches to content analysis that involve very different steps, none of which are described in enough detail. The use of references here would be highly beneficial.

Response: The authors regret that the description of the data analysis section was confusing and ambiguous. As advised by the reviewer, we have rewritten the data analysis section elucidating the steps followed as per the Braun and Clarke's approach. The section now also illustrates the themes and sub-themes identified from the analysis and presented in the manuscript.

Q. The tense/wording in the demographics table is confusing ex. "lived on street"...and the columns don't appear to be lined up which makes it challenging to read.

Response: The authors have made the necessary corrections in the demographic tables. The accommodation status has been changed to say – home-based and street-based. Further, 'employment' has been changed to reflect the 'employment status'. Necessary formatting has been done to align the content in the table appropriately.

Q. There is a note that only women who were married were asked about their children, however since no context of the situation for women in Delhi is provided, it is unclear why this was. If it was taboo to ask, this needs to be explained.

Response: The Indian culture strongly dissuades women from having sex (and thus child-bearing) before marriage. Women who do so are highly stigmatized and socially boycotted. Child-bearing without marriage is thus a huge social taboo across religions, economic class and regions in India. Questions to participants who have never been married can be interpreted as an attempt to malign a woman's character and hence this question was not asked to unmarried participants. As suggested by the reviewer, a footnote has been added to the table to explain the same.

Q. The job descriptions included with women's pseudonyms seem highly stigmatizing (ex. "beggar", "pick-pocketer") and I'm confused why these specifically were used to add context to women's lives? In addition, according to the demographics table, it appears some women had multiple sources of income, so it is not clear how you decided to identify their singular profession for the quotes. Perhaps something else could be used that could both contextualize women's lives and further humanize/empower their voices?

Response: In the previous version of the manuscript, singular professions were identified for the quote basis the primary job reported by the women at the time of the interview. However, as advised by the reviewer, the description of each participant quoted in the manuscript has now been limited to her age and key population group (injector or non-injector).

Q. Some of the quotes do not seem to illustrate the points made by the authors. For example, the authors' claim sex work gave some women "self-assurance or independence" but the quote following this does not convey this message. Perhaps more of the quote needs to be included, or the authors need to revise their understanding of the quote?

Response: The authors have reviewed all the quotes again including the inference drawn from each quote. Necessary modifications have been made in the presentation of the results to ensure there are no misinterpretation of the quotes. New quotes have been added to strengthen some of the study findings.

Q. In the section of violence, suicide (self-harm) and violence (from external sources) are confounded into one. This seems inappropriate, and the quotes provided only depict women's stories of self-harm. Further, although this was meant to contextualize women's lives, there is very little context in terms of women's childhood experiences and environments which are also important.

Response: Participants had highlighted the issue of violence by partners, clients of sex work etc. in the context of describing their relationships with them. In that discourse, only one woman mentioned about her attempt to commit suicide while a few women reported self-harm due to circumstances which they could no longer bear or due to their requests and feelings being unheard. However, the authors agree that self-harm should not be clubbed with violence from external source and the specific quote related to suicide has been dropped. However, quote of one of the participants who reported self-harm as a response to violence by her husband in context of our discussion on intimate partner violence has been retained.
While the authors agree with the reviewer on significance of childhood experiences and environment, we did not gather that information since the data collection was focused on contextualizing women's lives with respect to their SRH related behaviors and needs. Considering that the questions were open-ended, none of the participants also mentioned any childhood related experiences which they felt possibly influenced their current SRH-related behaviors except by some participants who discussed it only in context of drug use by family members.

Q. The results are very long, disjointed and repetitive. For example, condom usage is discussed in multiple areas under multiple subheadings. The results would benefit from being much more concise, and more clearly organized so that the reader can follow along. In addition, the results are categorized in some parts according to women's contexts and in other parts according to "vulnerabilities"...it seems that it would make a lot more sense to organize according to the "risk/vulnerability" and then within that section contextualize WHY that risk exists, with more information than just the behavior women partake in.

Response: As advised by the reviewer, we have restructured the results section to consolidate the findings such that there is minimal repetition. The results section now informs the reader about participants' behaviors and needs, and have included the context (the why) of those behaviors within the same description.

Q. Forced sex is included in "high risk sexual acts", instead of being classified as violence, assault or rape. This is highly problematic as it suggests this is a behaviour a woman is actively engaging in, instead of something she is a victim of. This is also why "risk profiles" are problematic as they embody the risk within the women, instead of rightfully on the systems, structures and processes that lead to them being exposed to high risk environments. Critical engagement with these issues would be highly beneficial and necessary to this paper and work as a whole before it could be considered publishable.

Response: The authors would like to clarify that we had classified it as a 'high risk sexual act' not to suggest the women's active involvement but to draw attention to the fact that they were involved in sexual behaviors which put them at greater risk of adverse SRH-related outcomes. The same was deliberated upon in the discussion section. However, as pointed out by the reviewer, we understand that misinterpretation is possible. Therefore, as advised, we have revised the language and based on the context in which women had mentioned of sexual violence, we have positioned it under pertinent sections of the restructured results section.

Q. The results seem to focus mostly on women's behaviours, rather than the context of WHY these behaviours are occurring. Re-framing the results to be more explicitly about the actual context is important not only for clarity, but for doing due diligence to women's lives, strengths, and their own visions for their health and well-being.

Response: As advised by the reviewer, the results section now informs the reader about participants' behaviors and needs, and have included the context (the why) of those behaviors within the same description.

Q. The authors talk about women's "unmet needs" for health care. As is true throughout the results, it is unclear if this is the assessment of the authors or if women themselves consider their health care needs unmet. Similarly, the authors say women "ignored symptoms of poor reproductive health"...is this the authors' assessment or what women said? It would seem from the quotes that women are not ignoring symptoms, so much as that they don't have the education, resources or skills to do anything about them, which is a very different issue. Clarification is needed. "Women gave limited importance to their healthcare needs" is again confusing as this seems to be the author's judgement/statement that is not backed up by any data. What seems more clear from this data is that women lack access to the right services, not that they don't care about their health. Similarly, the idea of stigma, and poor encounters with health care workers and systems is clearly evident in the data but is not given much attention by the authors...this is a very important context to why women may be experiencing poor sexual and reproductive health outcomes

Response: The study findings reflect mixed evidence of unmet healthcare needs and low uptake of health care services. The data in the manuscript shows that women were shy of discussing intimate problems in crowded settings, faced stigma at the hands of health care providers and embarrassment in explaining their symptoms. All of this suggests that women did want to access healthcare services but could not access them for above-mentioned reasons. On the other hand, women also indicated overlooking some of their symptoms such as menstrual irregularities, infertility since they were informed by their peers that it was a 'normal occurrence' for women who use drugs.

Some other symptoms such as vaginal discharge were also believed to be a common problem among women in general and hence were not considered important enough to warrant medical attention. These findings reflected that their behavior of 'not seeking healthcare' is stemmed in misconceptions and self-stigma for their drug use. However, lack of awareness is not always the case as despite being aware of possibility of infection transmission through their regular partners and various methods of contraception, women but did not use it for multiple reasons ranging from lack of partner concurrence to their own self-admitted inability to contraceptive adherence. Further, expectation of safe sex behavior from the client (such as client to bring the condom) is also suggestive of potential risk-taking behavior. The authors have revised the results presented on access to healthcare as mentioned above and have strengthened the discussion section to suggest the need to address issues at all levels – individual, family, community and institutional.

Q. The discussion can be strengthened and focused once the above revisions are addressed.

Response: The authors have reviewed the interviews again to make sure that the gaps highlighted by the reviewer are addressed at best, of course in certain cases (such as childhood experiences) are limited by the information sought by the interviews. The discussion section now focusses on how the contexts in which these women spend their lives and make certain decisions play a key role in planning interventions which can provide a more long-term approach to addressing their healthcare needs.

Q. I am not sure if a major revision can address the fundamental problems with this paper, as it may have required different questions to have been asked, or for the data to have been re-coded. However, since women participated in this study, presumably for the purpose of improving the services they receive in some way or contributing to something of import to themselves (although, again, this would need to be explained somewhere), I feel these revisions are important and necessary regardless of where/if the paper is published. Thank you to the authors for the effort in conducting this work and writing and submitting this paper. I hope that this feedback will prove helpful in improving this work and accomplishing yours and the participants' ultimate goals.

Response:The authors would like to thank the reviewer for her constructive feedback on the manuscript. The issues raised by the reviewer were pertinent to the subject in discussion. As mentioned in our detailed responses above, we have addressed most of the issues raised (except instances where we didn't seek information from the participants on certain issues). We sincerely hope that the manuscript can now be recommended for publication.

VERSION 2 – REVIEW

REVIEWER	Enisha sarin independent consultant
REVIEW RETURNED	15-Sep-2017

GENERAL COMMENTS	The revision has adequately addressed the concerns.