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ACCEDE
Access To CGMs for Equity in Diabetes Management

WILLINGNESS TO PAY FOR CONTINUOUS GLUCOSE MONITORING

IN THE PUBLIC SECTOR IN SOUTH AFRICA

NOVEMBER 2025

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ABBREVIATIONS

ACCEDE	Access to CGMs for Equity in Diabetes Management	**SD**	Standard Deviation
CGM	Continuous Glucose Monitoring	**SMBG**	Self-Monitoring of Blood Glucose
HbA1c	Glycated Hemoglobin A1c	**T1D**	Type 1 diabetes
LMICs	Low- and Middle-Income Countries	**USD**	United States Dollar
PSM	Price Sensitivity Meter (Van Westendorp method)	**WTP**	Willingness to Pay
SAHPRA	South African Health Products Authority	**ZAR**	South African Rand

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EXECUTIVE SUMMARY

Access to Continuous Glucose Monitoring (CGM) remains limited in South Africa's public sector due to high costs, despite clear clinical and quality-of-life benefits. This report presents findings from a willingness-to-pay (WTP) survey conducted among 167 participants living with type 1 diabetes (T1D), or their caregivers, enrolled in the ACCEDE trial across three public hospitals. The survey applied the Van Westendorp Price Sensitivity Meter to assess acceptable price ranges for both continuous and ad-hoc CGM use.

KEY FINDINGS:

- **THE ACCEPTABLE MONTHLY PRICE RANGE FOR CONTINUOUS CGM** was ZAR 279–543 (USD 16–30), with an optimal price point of ZAR 314 (USD 18); around 5% of the monthly minimum wage and only 16% of current market prices for CGMs.
- **FOR AD-HOC USE, THE ACCEPTABLE RANGE WAS SIMILAR** (ZAR 302–545 / USD 17–30) with a slightly higher optimal price of ZAR 350 (USD 20), suggesting periodic access may be more feasible for households.
- **PRICE STRONGLY SHAPED PURCHASE INTENT:** 83% of respondents were likely or very likely to buy at the good deal price (ZAR 514 / USD 29 per month) compared with 23% when the price was considered expensive.
- **USAGE PREFERENCES WERE HIGH:** more than half of respondents said they would want to use CGM for at least six months per year if available on an ad-hoc basis.
- **SUB-GROUP ANALYSES SHOWED HIGHER WTP** among adults, frequent glucose testers, and higher-income households, while lower-income groups reported much lower WTP – highlighting affordability constraints.

These findings demonstrate a mismatch between current market pricing (~ZAR 2,000 (USD 112) per month) and what public sector individuals can afford. While CGMs remain unaffordable at prevailing prices, interest in both continuous and periodic use is high, with ad-hoc models offering a potentially more realistic entry point. To expand access equitably, innovative procurement strategies, pricing adjustments, and public financing mechanisms will be essential.

INTRODUCTION

Diabetes is a chronic condition that requires strict, continuous monitoring of blood glucose levels to prevent acute and chronic complications. Self-monitoring of blood glucose (SMBG) plays a central role in this management, enabling people living with type 1 diabetes (T1D) to adjust their diet, physical activity and treatment. SMBG entails capillary fingerstick blood glucose testing multiple times per day. Many people with diabetes find this testing painful and cumbersome, often resulting in poor compliance to a glucose self-monitoring schedule. Furthermore, SMBG only provides limited visibility on daily and nightly glucose profiles, meaning that hypo- and hyperglycaemic episodes can be missed or detected with delay. In recent years, continuous glucose monitoring (CGM) has emerged as a major technological innovation, offering real-time blood glucose readings, alerts in the event of hypo- or hyperglycemia, and more precise monitoring of glycemic variations. Numerous studies show that CGMs reduce the time spent in hypo- or hyperglycemia, improve HbA1c control and are cost-effective in high-income countries, in type 1 and insulin-treated type 2 diabetes individuals[1–5]. At the same time, these devices not only improve clinical outcomes, but also improved quality of life due to reduced fear of hypoglycaemia and decreased reliance on finger stick testing[6,7].

In populations where CGMs are accessible to people with diabetes as standard of care and without additional out-of-pocket cost, many people living with T1D have switched from SMBG via fingerstick to the use of CGMs[8]. This is rarely possible for people living with T1D in the public sector in the Global South as CGMs are not provided as standard of care and the high cost of CGMs remains a major barrier to their adoption. Whilst there has been some encouraging progress in the adoption of CGMs in South Africa, this is largely limited to the private sector where CGMs are fully or partially covered by private insurance. It is estimated that approximately 16% of the 31,000 people living with T1D use CGMs at least occasionally[9,10]. In 2024, 194,000 sensors were sold in the private sector in South Africa at an average price of R928 per sensor[11] (~R2000/month). However, in a context of high unemployment (33%)[12] and low earnings – with more than one-third of employees earning below the monthly minimum wage of <R6000[13] (USD 335) – an out-of-pocket cost of R2000 (USD112) on CGM sensors per month is unaffordable for the vast majority of people. This financial burden contributes to inequality of access.

The willingness-to-pay (WTP) analysis presented here is part of the ACCEDE study, a pragmatic three-arm randomized controlled trial evaluating continuous and periodic CGM use compared with standard of care in South Africa[14]. In South Africa, 248 people with type 1 diabetes were recruited from three public sector hospitals including both children and adults with poorly controlled diabetes at baseline (HbA1c ≥10%). Participants were randomized either to continuous CGM use, periodic CGM use (wearing the device for two weeks every 3 months), or to standard fingerstick-based monitoring (SMBG). The trial assessed the impact of these strategies on clinical outcomes, quality of life, cost-effectiveness, and acceptability, providing much-needed evidence for policy decisions in resource-constrained settings.

The objective of this report is to evaluate the WTP for CGMs among people living with T1D in the public sector in South Africa, based on participants in the ACCEDE study. Assessing WTP provides insight into how people living with T1D perceive the value of CGMs, highlighting acceptable price ranges and affordability thresholds. Beyond clinical benefits, WTP reflects the trade-offs individuals are willing or able to make given their economic circumstances. This information is critical for informing pricing strategies, reimbursement discussions, and policy decisions that could expand equitable access to CGMs and reduce the current inequality of care.

WTP for CGM devices in South Africa was assessed in 2023 through a mixed online and clinic-based survey of 264 adults living with diabetes (both type 1 and insulin-using type 2)[15]. The study found an acceptable monthly price range of USD 15–32, with an optimal WTP of around USD 26—substantially below current market costs. Notably, the sample was skewed toward participants wealthier than the national average and with higher rates of health insurance coverage (60% had health insurance vs. a national average of 15%), suggesting that population-wide WTP is likely to be lower. This new WTP analysis focuses exclusively on people with T1D enrolled in the ACCEDE trial from public sector hospitals. It therefore provides a more realistic picture of affordability among those most dependent on the public health system and facing greater economic constraints. It also introduces, for the first time, questions on periodic or ad-hoc CGM use, recognizing that individuals may be more willing and able to afford these devices if purchased for periodic rather than continuous use.

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METHODOLOGY

STUDY DESIGN

This WTP study was nested in a larger pragmatic, three-arm randomized controlled trial on the effectiveness, feasibility, acceptability, and cost of the use of CGM devices among people living with T1D and accessing care in the public sector in South Africa. The trial was conducted in 3 public sector hospitals in South Africa: two based in Cape Town (Western Cape province), and one in Pretoria (Gauteng province). A total of 248 individuals were enrolled and randomized across three arms: Arm 1 (continuous CGM use throughout the intervention period), Arm 2 (periodic CGM use for two weeks every three months), and Arm 3 (standard of care control). After completing their final study visit, participants with T1D from all arms were invited to take part in a WTP survey, conducted either telephonically or in person at the study site. The CGM device used in this trial was the Abbott FreeStyle Libre 1 (replaced with the FreeStyle Libre 2) (Abbott Diabetes Care, Alameda, CA, USA), which is available in South Africa and approved by the South African Health Products Authority (SAHPRA)[16]. The FreeStyle Libre sensor has a wear time of 14 days – requiring two sensors per month. All participants received the device free of charge along with training on its use.

WTP was assessed by using Van Westendorp's price sensitivity meter (PSM), a widely used method for analyzing how individuals perceive prices[17]. The approach relies on four questions that measure price perception by asking respondents to indicate:

1. **The price at which a product would seem too cheap that quality would be questioned ("too cheap"),**
2. **The price they consider affordable ("a good deal"),**
3. **The price that is considered expensive but still acceptable ("getting expensive"),**
4. **The price at which it becomes too expensive to purchase ("too expensive").**

In this study, the four fundamental questions from the Van Westendorp PSM method were incorporated into a survey in order to assess respondents' price expectations and WTP for both continuous CGM use and ad-hoc/periodic CGM use. In this study, "ad-hoc use" referred broadly to occasional or periodic CGM use rather than continuous wear (see Appendix). By cross-referencing these responses, the PSM identifies both a range of acceptable prices and an 'optimal' price point. The analysis provides both the price range perceived as reasonable (the interval between the intersection of "too cheap" and "getting expensive", and the intersection of "good deal" and "too expensive"), as well as an optimal price that best balances affordability with perceived value (intersection of "too cheap" and "too expensive").

STUDY POPULATION

Individuals were eligible to participate in the broader study if they had T1D for more than 2 years, with poor glycaemic control (HbA1c ≥10% in the past 3 months and no HbA1c <8% in the past 9 months) and were receiving care at one of the three public sector study clinics; caregivers were eligible only if the child or adolescent they cared for was enrolled in the study. Exclusions applied to those very young (<4 years), recently diagnosed with T1D (<2 years), previously or concurrently using CGM, living with type 2 diabetes, pregnant, or unwilling/unable to provide informed consent. Eligible participants were contacted by telephone and invited to an information session on site. Those who were interested then underwent an examination to confirm their eligibility and completed the informed consent process.

The study spanned 15 months (September 2023–June 2025), consisting of a 9-month intervention phase followed by 6 months of follow-up. At the final visit, individuals from the standard of care arm were provided with a CGM. The WTP survey was conducted just after the final follow-up visit; as such, no participant remained CGM naïve. Analyses also considered key sub-populations, including intention-to-treat, fully compliant participants (those completing all visits with ≥70% CGM wear time), as well as groups stratified by income, age, and frequency of glucose testing.

DATA COLLECTION PROCEDURES

As part of the trial, participants (or their caregivers) from all study arms were invited to complete a WTP survey after their final study visit, either in person at the study site or telephonically. Offering both options provided flexibility for those not willing to attend the clinic just for this survey, while providing trust and confidentiality to those concerned about discussing financial matters over the phone. A convenience sampling approach was used, aiming to include as many participants as possible who completed the final visit. Data were collected by trained research assistants using an electronic data capture system over a three-month period (May–July 2025). Participants received financial compensation for their time, regardless of whether the survey was conducted on site or telephonically.

All values were reported in South African Rands (ZAR) and converted to United States Dollars (USD) at the rate of R17.90/USD (the average exchange rate over the period May to July 2025)[18].

DATA MANAGEMENT AND ANALYSIS

High-quality data standards were maintained through risk-based monitoring, routine data validation, and quality control checks. Site staff entered data into FIND's electronic data capture system. Data were secured through restricted access, encryption, and retention procedures in line with regulatory and institutional requirements. All analyses were conducted using R software version 4.5.1 and Microsoft Excel.

For comparability across devices from other manufacturers with varying sensor lifespans, WTP values in the current study were reported as monthly costs. For the FreeStyle Libre's two-week sensor wear time evaluated in this study, the WTP per month corresponds to approximately 2 sensors.

ETHICAL CONSIDERATIONS

The trial was designed in accordance with the principles of the Declaration of Helsinki and country-specific regulatory and ethics requirements and has been approved by all relevant Institutional Review Boards and Independent Ethics Committees. Written informed consent (and assent where applicable) was obtained from all participants or their caregivers before enrolment.

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FINDINGS

STUDY POPULATION

Of the 248 participants enrolled in the ACCEDE trial, 224 completed the final visit (90%) and 167 (75% of those who completed the final visit) completed the WTP survey. The majority of the participants completed the survey face-to-face (64%) versus via telephone. The study population was characterized by high baseline HbA1c levels (mean 12.1%) (driven by the inclusion criteria for > 10%), checked blood glucose on average 3 times per day, and low-income levels (44% earned less than R5000 per month and 43% were unemployed). **Table 1** shows the respondents' sample characteristics.

		TOTAL
	Total participants enrolled (N)	248
	Total completed final visit (N)	224
	Total completed WTP survey (N)	167
	Face-to-face	64%
	Age (mean, SD)	22 (12)
	Women/girl	60%
	Years since diagnosis (mean, SD)	11 (8)
	Baseline HbA1c (%) (mean, SD)	12.1% (1.9%)
	Baseline daily glucose testing frequency (mean, SD)	3.3 (1.5)
INCOME LEVEL (%)	Less than R5000	44%
	R5,000– R9,999	24%
	R10,000 – R14,999	14%
	Greater than R15,000	10%
	Prefer not to say	9%
SOURCE OF INCOME (%)	Salaries	50%
	Grants	25%
	Other	13%
	Pensions	4%
	Business income	2%
	Prefer not to say	7%
EDUCATION LEVEL (%, CAREGIVER, IF CHILD)	Primary	10%
	Secondary	68%
	Tertiary	22%
EMPLOYMENT (%, CAREGIVER, IF CHILD)	Employed	47%
	Unemployed	43%
	Other (Retired, Student, Homemaker)	10%

TABLE 1: Respondents' sample characteristics

WILLINGNESS TO PAY FOR CONTINUOUS CGM

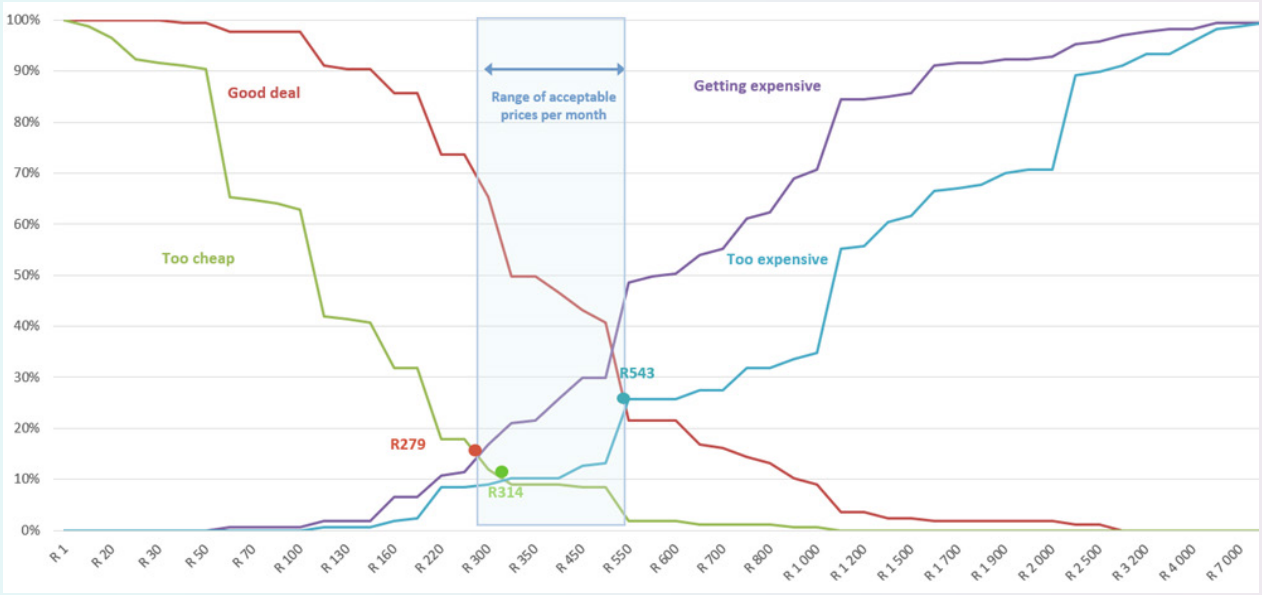


FIGURE 1: WTP per month for continuous CGM (ZAR)

Analysis using the Van Westendorp PSM indicated that the acceptable monthly price range for continuous CGM use among this public sector cohort was approximately ZAR 279 - 543 (USD 16 - 30), with an optimal price point of ZAR 314 (USD 18) (**Figure 1**). As the CGM used in this study has a two-week lifespan, the price per sensor would be approximately half of these reported monthly values. 71% of participants considered a price of R2000/month too expensive.

Perceptions of price strongly influenced purchase intent (**Figure 2**): 83% of respondents were likely or very likely to buy a CGM at the good deal price (ZAR 514 / USD 29 per month), compared with 23% when the price was judged expensive.

FIGURE 2: Likelihood of Continuous CGM Uptake at Good Deal vs. Expensive Price Points

WILLINGNESS TO PAY FOR PERIODIC/AD-HOC USE

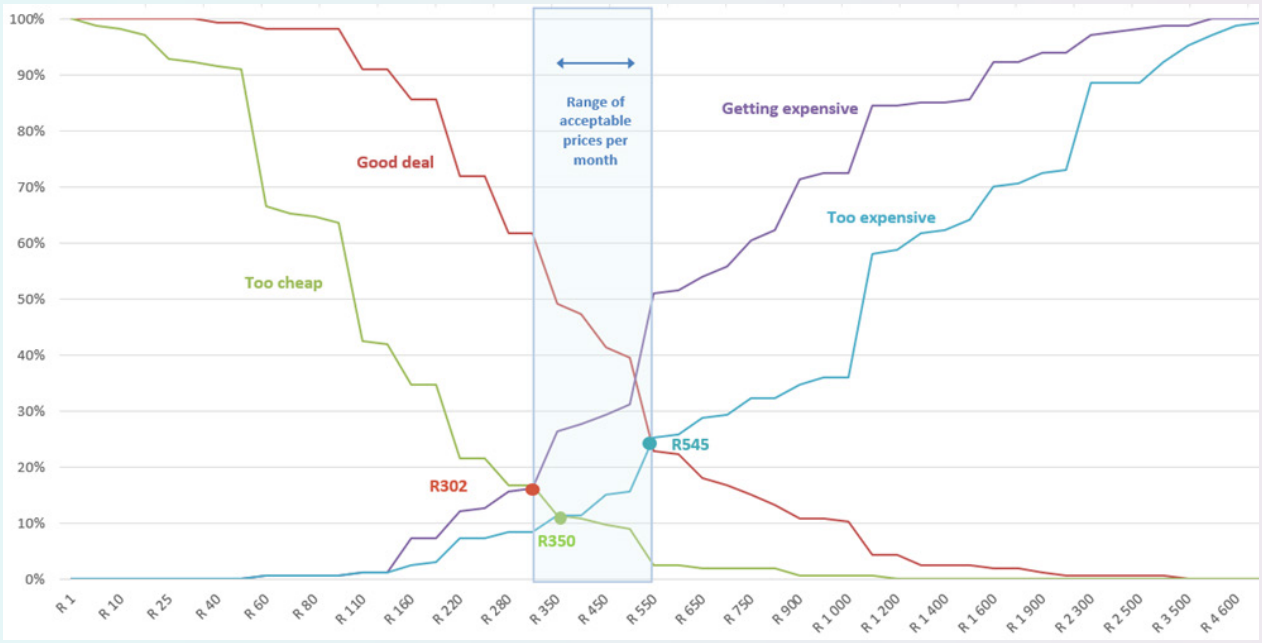
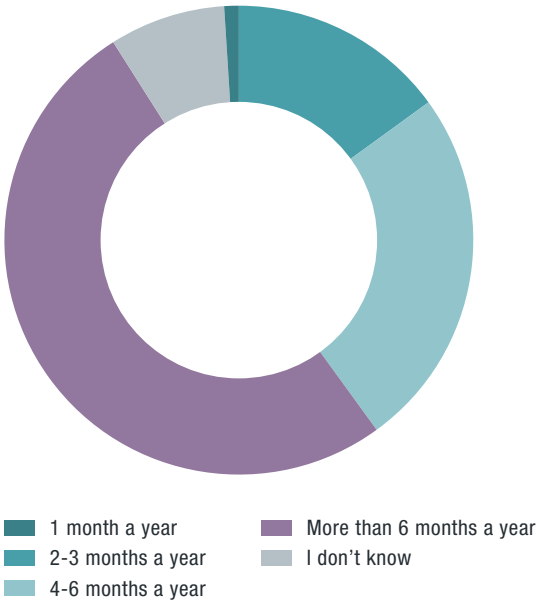


FIGURE 3: WTP per month for period/ad-hoc use

The acceptable price range for periodic use per month was ZAR 302 - 545 (USD 17 - 30), with a slightly higher optimal price of ZAR 350 (USD 20) as compared to continuous use suggesting that periodic access may represent a more feasible entry point for CGM adoption in the public sector (**Figure 3**).

When asked how many months per year they would like to use a CGM on an ad-hoc basis, most respondents preferred longer durations (**Figure 4**): the majority indicated more than 6 months per year, followed by 4–6 months and 2–3 months. Very few selected only 1 month, and a small proportion were unsure.

FIGURE 4: Desired frequency of CGM ad-hoc use



SUB-GROUP ANALYSIS

Sub-group analyses indicated that WTP showed some variation by income, location, age, self-reported frequency of glucose testing and whether they were considered fully compliant CGM-users or not (those completing all visits with ≥70% CGM wear time) (**Figure 5**). Participants from higher-income households, adults or those testing blood glucose >3x/day reported higher WTP R413 – R538/month. By contrast, those from lower-income households, younger in age, with less frequent testing, or not compliant users of CGM expressed substantially lower WTP. However, overall, there was substantial overlap in the acceptable price ranges across subgroups, suggesting that WTP did not differ meaningfully by age, testing frequency, trial arm, or province. The most pronounced difference was observed for income (with very little overlap in acceptable price ranges), where higher-income respondents indicated substantially higher WTP compared to other respondents, underscoring affordability constraints.

Across all subgroups, the good deal price was consistently higher than the optimal price. This reflects the nature of the PSM, where the 'optimal price' represents the balance between too cheap and too expensive, while the 'good deal' price captures where respondents feel they are getting clear value before the product starts to feel expensive. This means the good deal price captures WTP for value, while the optimal price captures the price point that balances acceptability across the entire group, minimizing resistance to adoption.

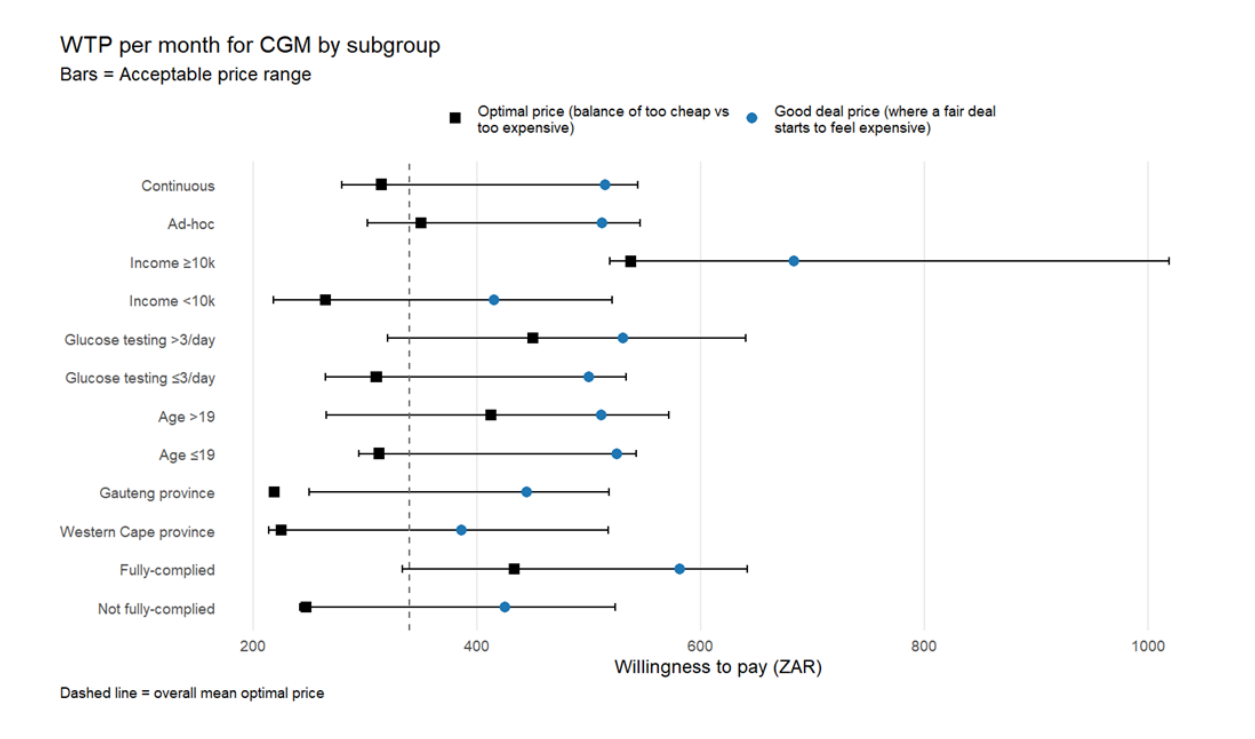


FIGURE 5: WTP per month for CGM by subgroup

Note: In Gauteng, the calculated optimal price lies below the acceptable range, suggesting that the balance point between 'too cheap' and 'too expensive' is not a realistic price anchor in this subgroup. Instead, the acceptable range (250–518 ZAR) and the good deal price (444 ZAR) better capture perceived affordability.

DISCUSSION

This study found that, on average, respondents were willing to pay approximately ZAR 314 (USD 18) per month for continuous CGM use, equivalent to roughly 5% of the monthly minimum wage, or 16% of the current price of sensors per month. This corresponds to a WTP of approximately USD 9 per sensor (in the case of the FreeStyle Libre with a wear-time of 14 days). Subgroup analyses showed higher willingness among adults, frequent glucose testers (>3 times/day), those from higher-income households, and fully compliant CGM-users; while respondents from lower-income households reported substantially lower WTP, underscoring affordability constraints. Perceptions of price strongly influenced purchase intent: 83% of respondents reported being likely or very likely to buy a CGM at the good deal price (ZAR 514 / USD 29 per month). Importantly, WTP was somewhat higher for ad-hoc or periodic use (optimal ZAR 350 / USD 20), and most respondents preferred to use CGMs for extended periods if available; over half indicated they would want access for at least six months per year.

These results align with the 2023 South African WTP survey, which reported a similar acceptable monthly price range (USD 15–32 vs. USD 16 – 30), but had a higher optimal price point of USD 26 (versus USD 19)[15]. This earlier study largely sampled a wealthier, urban population, 60% of whom had health insurance, and included both type 1 and insulin-using type 2 diabetes respondents. By contrast, the current analysis reflects a more resource-constrained cohort dependent on the public sector for care, with lower income and higher unemployment, offering a more realistic picture of affordability thresholds.

In South Africa, approximately 31,500 people live with T1D, with an estimated 80% relying on public sector services where CGMs are not routinely available. Current market prices of around R1,000 per sensor (≈R2,000 per month) remain far above the affordability levels indicated in this study with 71% of respondents indicating this price was too expensive. CGM pricing has largely been set in high-income country markets, and these levels are not viable in the South African context. In addition, while this study focused on T1D, around 27% of the country's four million people with type 2 diabetes are insulin users and would also benefit from CGM access, further underscoring the need for affordable pricing[19].

For comparison, the out-of-pocket cost of SMBG is approximately R300–R1,000 per month for individuals testing 2–6 times per day. Although SMBG is officially provided free of charge in the public sector, in practice many individuals incur these costs due to supply shortages or inconsistent access. Thus, CGMs not only remain unaffordable at current market prices for SMBG but also risk widening inequities if introduced without a more sustainable financing and pricing model.

In the context of high unemployment (>30%)[12] and a minimum wage below R6,000[13], widespread access to CGMs will require significant price reductions, innovative procurement approaches, or partial coverage through public financing mechanisms. While out-of-pocket payment runs counter to the principle of free care at the point of service available in the South African public healthcare system, these results suggest that tiered access models—for example, enabling periodic ad-hoc use or introducing co-payment schemes for those able to contribute—could broaden access while reducing inequities. Ultimately, WTP data such as these provide a valuable foundation for engaging government, payers, and manufacturers in designing models that balance affordability, sustainability, and equity in the integration of CGMs into the South African health system. Together, these findings suggest that while affordability remains a major barrier, models that allow periodic access or align pricing with perceived value could improve feasibility within constrained household budgets.

This WTP analysis has several limitations. First, WTP reflects stated preferences rather than actual purchasing behavior and may overestimate affordability in real-world settings. Second, although the study sample is more representative of the public sector than previous surveys, participants were enrolled in a clinical trial and received CGMs free of charge, which may have influenced perceptions of value and affordability. Third, the analysis focused on people with T1D and their caregivers; while relevant to this high-need group, results cannot be directly generalized to insulin-using type 2 diabetes individuals, who make up a much larger population. Fourth, in the WTP survey, prices were anchored to the estimated out-of-pocket costs of SMBG (R300–R1,000 per month depending on testing frequency), which likely influenced the values participants reported for CGMs. Finally, because care in the public sector is generally expected to be free at the point of service, some participants may not have been fully familiar with the concept of paying out-of-pocket for healthcare-related expenses, which could affect how WTP responses were interpreted.

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APPENDIX

WTP SURVEY

Annex 24: Willingness to pay survey

Survey Date: __ __/ __ __ __ / __ __ __ __ (dd/mmm/yyyy)

Survey Format: ☐ In person ☐ Telephonic

What is your total monthly household income (before deductions), from all sources? Please include salaries, grants, business income, pensions, and other income from all members of the household.	☐ Less than R5,000 ☐ R5,000 – R9,999 ☐ R10,000 – R14,999 ☐ R15,000 – R24,999 ☐ R25,000 – R49,999 ☐ R50,000 or more ☐ Prefer not to say
Please indicate your main source of income. Please tick all that apply.	☐ Grants ☐ Salaries ☐ Business income ☐ Pensions ☐ Other ☐ Prefer not to say

We would like to ask a few questions to understand your willingness to pay for a continuous glucose monitoring device.

Note to Research Assistant/Individual administering the survey: The below description of a CGM is only relevant for those who have not used it during the trial. Skip to Section 1 if they have used it either continuously or periodic during the trial.

We want you to try think about how a continuous glucose monitoring (CGM) device could benefit you. For those who have not used a CGM device, or not familiar with it, this is what it looks like *(if survey conducted telephonically, please skip to the description below)*:

Continuous glucose monitoring

A CGM device helps you track your glucose (sugar) levels **every few minutes, 24 hours per day,** through a **sensor** applied on the skin, either on the stomach or arm.

You would be able to see your glucose (sugar) levels, trends, and alerts on your smartphone or an external reader. You need to replace the sensor between 1 to 4 times per month.

The continuous glucose monitoring device allows you to:

- **prick yourself less,** as one sensor lasts around 2 weeks
- act more quickly to **minimise low and high blood glucose** (sugar)
- **easily track** your diet, exercise, and insulin requirements
- **have more data** for your doctor's appointment

Section 1: Willingness to Pay for a CGM on a continual basis

We are going to ask you a few questions about the price **per month** in South African Rands that you would be willing to pay **out of your own pocket** to use a continuous glucose monitoring device. These questions are simply to help you consider the idea of purchasing a CGM—there is no expectation that you will actually buy one. Before answering, read each question carefully and consider the benefits that this device may bring to you.

Currently, the out-of-pocket cost of **self-monitoring of blood glucose (finger-pricking)** is around **R300-R1000 per month** for individuals who check their blood glucose 2-6 times per day.

Note: Out of pocket payments are all the costs that are not covered by your medical aid if you have one, or provided for free by government.

Also Note: For monthly use, we are asking what you would be willing to pay for one full month of CGM use, regardless of how many sensors might be required during that month.

Number	Question	Answer
1.1	At what price per month would you begin to think the continuous glucose monitoring device is **too expensive** to consider?	R _____ per month
1.2	At what price per month would you begin to think the continuous glucose monitoring device is **getting expensive,** but you still might consider it?	R _____ per month
1.3	At what price per month would you think the continuous glucose monitoring device is a **good deal**?	R _____ per month
1.4	At what price per month would you consider the continuous glucose monitoring device to be priced **so low** that you would not trust the results?	R _____ per month
1.5	At the price per month you said was **'getting expensive'** [price_getting_expensive], how likely would you be to buy?	☐ Very unlikely ☐ Unlikely ☐ Unsure ☐ Likely ☐ Very Likely
1.6	At the price per month you said was **'a good deal'** [price_good_deal], how likely would you be to buy?	☐ Very unlikely ☐ Unlikely ☐ Unsure ☐ Likely ☐ Very Likely

Section 2: Willingness to Pay for a CGM on an ad-hoc basis

Now we'd like you to think about using a CGM device only occasionally — for example, during certain months when you want extra information about your glucose levels to check trends or adjust treatment. This could be during times of stress, when changing your diet or medications, or when you're not feeling well.

This is sometimes called "ad hoc" or "intermittent" use.

For the next few questions, please think about what you would be willing to pay out of your own pocket to use a CGM device for **just one month,** not every month.

Note: For occasional use, we are asking what you would be willing to pay for one full month of CGM use, regardless of how many sensors might be required during that month.

Number	Question	Answer
2.1	At what price for one month of ad-hoc CGM use would you begin to think the device is **too expensive** to consider, even for short-term use?	R _____ for one month
2.2	At what price for one month of ad-hoc CGM use would you begin to think the device is **getting expensive,** but you might still consider it for short-term use?	R _____ for one month
2.3	At what price for one month of ad-hoc CGM use would you consider the device a **good deal** for short-term use?	R _____ for one month
2.4	At what price for one month of ad-hoc CGM use would you consider the price **so low that you would not trust the results** or device quality	R _____ for one month
2.5	At the price you said was **'getting expensive'** for one month of CGM use, how likely would you be to actually pay for and use it?	☐ Very unlikely ☐ Unlikely ☐ Unsure ☐ Likely ☐ Very Likely
2.6	At the price you said was a **'good deal'** for one month of CGM use, how likely would you be to actually pay for and use it?	☐ Very unlikely ☐ Unlikely ☐ Unsure ☐ Likely ☐ Very Likely
2.7	In a typical year, how many months do you think you would want to use a CGM on an ad-hoc basis?	☐ 1 month a year ☐ 2–3 months a year ☐ 4–6 months a year ☐ More than 6 months a year ☐ I don't know

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