rheumatoid arthritis. Understanding about the disease symptoms: 50,5% respondent answered they to do not know RA symptoms; 29% correctly identified joint swelling; 17.4% correctly identified morning stiffness; 12.6% correctly recognized extreme fatigue as a symptom; and only 6.5% correctly identified that crunching and grinding of the joints is not a symptom. Understanding about disease risk factors: 49.4% of participants responded they do not know the risk factor for RA, only 7% correctly identified genetics as a factor; 17% knew that women are more vulnerable than men; only 3% correctly stated that smoking can increase the risk of developing RA; and 34% stated that undertaking exercise and obesity is also a risk factor and 23% identified sore throat can increase RA. Understanding about disease impacts: 21.1% correctly recognized that RA affects a person's ability to walk short distances; 55% did not know how RA affects person`s quality of life, 40.3% correctly stated that RA affects a person's life expectancy; but only 11% knew that the disease affects the internal organs. In total, 12% of respondents saw information about the RA and 82% said public RA awareness needs to be improved.

Conclusion: In Mongolia, public awareness of rheumatoid arthritis was poor. Most of the participants responded to do not know. Other participants who have not responded to do not know that most of them misidentified disease symptoms, risk factors and impacts. The only good thing was most of the participants thought awareness of RA improvement certainly. A good awareness of RA can be one of the basic solutions for the early diagnosis of RA in Mongolia.

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AB1342 TRANSLATION AND ADJUSTING THE PATIENT GUIDE FOR OSTEOARTHRITIS INTO DUTCH. LESSONS LEARNED FROM THE JIGSAW-E PROJECT

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Background: In the UK a guidebook was co-developed with UK patients during a OA research study (1). Within the JIGSAW-E (Joint Implementation of Guidelines for Osteoarthritis in Western Europe) project the guidebook is disseminated and implemented in clinical practice in 5 countries: UK, The Netherlands, Norway, Denmark and Portugal. We translated and adapted the English guidebook for use in the Netherlands.

Objectives: To describe the process of translating and adjusting the guidebook into Dutch, and to summarize the key lessons learned.

Methods: Starting point was a paid translated version of the guidebook. The translation was reviewed by an interdisciplinary working group and distributed among stakeholder organizations. Data collections took place by reports of working group meetings, written feedback from stakeholder organizations and patients' interviews focusing on their information needs. Along the way a logbook of adaptations was kept. After triangulation of findings, adaptations were clustered in six preliminary categories and, together with lessons learned, agreed upon in a consensus meeting with the working group.

Results: The working group convened fifteen times. Ten patients were interviewed about the readability and usefulness of the OA guidebook. Eight out of thirteen stakeholder organizations provided feedback on the draft guidebook. Advice for adaptations related to the following preliminary categories: language; patients' needs; cross-cultural differences; health care system; scientific evidence; structure and layout (see Table 1 for examples). Lessons learned related to the low quality of the initial translation, selection of representative working group members, selection of stakeholder organizations, and required time for thorough deliberation during meetings.

Conclusion: Important ingredients for a successful translation and cross-cultural adaption of a guidebook (or other patient material) are: time, a professional translation (sufficient budget), relevant stakeholders, and patients who can be critical. Patients who were interviewed about the guidebook added valuable patients' information needs, relevant to the cross-cultural adaptation. A draft framework of categories for cross-cultural adaptation is proposed.

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Categories	Examples
Language	Joint pain, osteoarthritis (OA) and arthritis are used interchangeably; explanation in Dutch is needed (gewrichtspijn, artrose, reuma, ontsteking); Translation of English expressions, such as 'no pain, no gain')
Patients' need	More practical tips for specific OA type (hand, knee, hip); 'people with OA' is preferred over 'patients'
Cross-cultural differences	Compared to what there is already in the Netherlands, the tone in the guidebook is much better, less paternalistic; Photographs of people cycling are needed
Health care system	The central role of the nurse in primary care OA management in the UK versus that of the physiotherapist in the Netherlands
Scientific evidence	Due to new scientific insights we deleted the part on insoles
Structure and layout	Photographs should be of younger people and other cultural backgrounds in the Netherlands; Shorter sentences and more subheadings

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AB1343 EFFECTIVENESSOF A RHEUMATOLOGY EDUCATIONAL PROGRAM TO IMPROVE METHOTREXATE PRESCRIBING PRACTICES FOR RHEUMATOID ARTHRITISIN THE SOLE PUBLIC ADULT RHEUMATOLOGY CLINIC IN ETHIOPIA

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Background: Treatment of recent onset Rheumatoid Arthritis (RA) is key to preventing deformities. Initial treatment with methotrexate (MTX) is standard of care. RA treatment in resource-limited countries is complicated by competing health priorities and a lack of rheumatologists. The sole public adult rheumatology clinic in Ethiopia, is at Tikur Anbessa Specialty hospital (TASH) (Addis Ababa). Due to the lack of rheumatologists, care is provided by internists with limited rheumatology training.

Objectives: To evaluate changes in RA management practice patterns following a series of educational activities provided by visiting rheumatologists.

Methods: With local faculty support, visiting rheumatologists conducted educational activities at TASH between July 2016 and December 2018 (2 continuing medical education workshops; 4 clinical preceptorships lasting 2-4 weeks each). Clinical charts of a convenience sample of RA patients seen in the TASH rheumatology clinic were reviewed in September 2016 (n=48) by a team of rheumatologists and a second set in December 2018 (n=78) by an internist. Socio-demographics, arthritis features, treatment patterns and drug safety monitoring were recorded when documented. Practice patterns were compared between 2016 and 2018 using univariate statistics.

Results: The patients were mainly female (90%) with a mean (standard deviation) age of 36(13) years, resided in Addis Ababa (61%) and received government funded health care (57%). When documented, (95/117; 81%) had polyarthritis and (42/55; 76%) clinical joint deformity (2016 vs 2018 p=NS). More patients were seropositive in 2016 compared to 2018 (32/43 vs 14/75 p<0.001) and more had radiographic damage (erosions, joint space narrowing, periarticular osteopenia) (21/27 vs 39/71 p<0.05). Between 2016 and 2018, prednisolone use remained common (92% in 2016 vs 99% in 2018 p=0.05) often in high doses (last visit daily dose 7.5mg (0-100) vs 5mg (0-100); p=NS; maximum daily dose 7.5 (0-100) vs 20 (0-100) p=NS) with continued documentation of steroid toxicity (45% vs 20%). The only available DMARDs prescribed were MTX (112/127; 97%) and chloroquine (50/125;40%). Median prescribed weekly MTX dose increased between 2016 and 2018 (starting dose 5 vs 7.5 mg/week p=0.01; maximum dose 7.5 vs 12.5 mg/week p<0.0001) and was co-prescribed with folate by 84% in 2016 vs 93% in 2018 (p=NS). Documentation of drug safety for those prescribed MTX improved with

adequate pre-MTX labs (hematology, renal and liver panel and or hepatitis serology) requested by 46% in 2016 to 90% in 2018 (p<0.0001). When documented, MTX use was often interupted (2016 17/24; 2018 14/43 p=0.003) and mainly due to limited drug availability.
Conclusion: An educational program conducted with support from the local medical community has potential to improve management of rheumatic disease in resource limited regions without adequate rheumatology capacity. However, interventions must be maintained over time and changes in practice measured to ensure that appropriate diagnosis and safe prescribing practices continue until local rheumatology expertise and capacity is available.
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AB1344 'CLINICAL ASSESSMENT OF THE MUSCULOSKELETAL SYSTEM' HANDBOOK AND ACCOMPANYING VIDEOS: 15 YEARS OF USE

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Background: 15 years ago, Arthritis Research UK (ARUK) produced the 'Clinical Assessment of the Musculoskeletal (MSK) System' handbook and a set of accompanying videos; 'Regional Examination of the Musculoskeletal System'.(1) There has been an evaluation of the use of this resource showing that they are widely used among medical students and healthcare professionals. Recently, ARUK has merged with Arthritis Care to create Versus Arthritis, and previous publications are due to be rebranded.
Objectives: This project aims to review how the handbook and videos are being used 15 years on. The secondary aim is to gain insight into any changes that may need to be made going forward as Versus Arthritis seeks to revise and update the original materials.
Methods: In September 2018, a clinical group was formed to review the current handbook's content and format. The project team was invited to take part in the surveys and disseminate them within their professional networks and across every UK medical school.
Results: 78 people took part in the survey; this included 61 users (students and trainees) and 17 medical school teachers.
User Survey: '*How to access the handbook?* respondents said online (36%), via an app (31%) or printed version (10%). 83% of respondents said they found the handbook very useful, 100% said it was easy to understand, 95% said it was well illustrated, and 75% said the video clips were very useful. 100% of respondents said the handbook did not contradict any previous teaching received.
When asked what would improve the handbook, the most popular response was case studies. When asked what the most useful thing was, most respondents commented on the structure and how clear and concise it was. When asked what the least useful thing was, respondents felt it lacked detail regarding the rationale behind the purpose of the examinations.
Teacher Survey: 17 medical school representatives completed the survey. 94% of respondents use the resource. Most provide their students with the online version of the handbook (64%). 88% thought the resource was very useful for their students. 94% said the resource maps well to the current MSK curriculum. When asked what would improve the handbook the most popular response was abnormal examination findings. The least popular response was patient exercise videos and sheets.
Content Review: Several comments were made suggesting the use of more appropriate language. Recommendations were made to introduce sections on physical activity, self-management and the multidisciplinary team involvement. A suggestion was made to include the patient's 'ideas, concerns and expectations' concept.
Conclusion: The consensus is that the resource is already very good and maps well to the MSK curriculum taught by the medical schools. It would benefit from adding new contents, e.g. examination clips of patients with pathology. We would need to be wary of overcomplicating the purpose of the new resource.
It was also highlighted that the resource would benefit from a refresh of the layout, including clear headings and more up to date images and diagrams. Several comments were made around the format to include an online resource that students could use to incorporate examination videos with experts explaining the findings.

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AB1345 CONTEXTUAL FACTORS IMPACTING OSTEOARTHRITIS MANAGEMENT IN URBAN AND RURAL COMMUNITY-DWELLING SENIORS: AN ANALYSIS BASED ON THE INTERNATIONAL CLASSIFICATION OF FUNCTIONING DISABILITY AND HEALTH

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Background: Living with arthritis requires lifelong management that can be influenced by person, place and context.
Objectives: The objectives of this study were to: (1) identify contextual factors that influence OA management in rural and urban-dwelling seniors, and (2) examine how contextual factors identified by rural and urban-dwelling seniors are explained in terms of the ICF framework
Methods: Semi-structured interviews were conducted with 20 community-dwelling seniors in Ontario, Canada.; purposivel inclding 11 seniors from an urban setting and 9 seniors from a rural setting, all over the age of 65, and previously diagnosed with OA. Broad questions on self-management and information weeking were explored. Interview concepts related to the environmental and contextual factors component were extracted from interview transcripts and organized into subthemes. Meaningful concepts were linked by 2 raters to ICF categories according to established linking rules. Descriptive analyses were performed.
Results: A total of 891 meaningful concepts were identified; 481 from interviews with 11 urban-dwelling seniors and were linked to 54 ICF categories: 24 Environmental Factors, 21 Activities and Participation, and 9 Body Functions and 410 meaningful concepts from interviews with 9 rural-dwelling seniors: 57 ICF categories: 27 Environmental Factors, 24 Activities and Participation, and 6 Body Functions. Within Activities and Participation component, "d839 Education" was the most code for both groups. From the Body Functions component, "b1800 Experiences of Self" followed by "b1301 Motivation" were most mentioned. Environmental factors represented 203 of 481 (42.2%) urban concepts and 253 of 410 (61.7%) rural concepts. The concepts linked to the Activities and Participation category were similar across urban and rural groups (17.3% and 17.1%). Personal Factors (e.g. "adapting to life with OA", "self-sufficiency", "pain tolerance", "age") or "nc - not covered" (e.g. "feeling old", "embarrassed by OA", "being a burden") were not coded. In 12.2% urban and 20.6% rural content was labeled as Personal Factors. Chapter e5 services, systems and policies was the chapter with the highest coverage overall. Within the environmental factors "e355 Health Professionals" was the most common code for both urban and rural groups, and mentioned in almost all interviews. Participants frequently discussed physician's attitudes and misconceptions towards patients with OA.
Conclusion: The complex interaction of personal and environmental factors impacting OA management in both urban and rural communities was illustrated. Rurality influences some aspects of ths complexity, but many common themes occur.

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