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A Study of HIV-related knowledge transfer at Swedish MNEs operating in South Africa

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Abstract: Researchers have foreseen HIV/AIDS to be one of the biggest threats to the general business climate and profitability of companies in Africa. The virus thus affects individual workers, companies as well as the labor market as a whole. This makes the workplace, management, employees and trade union representatives essential players in preventing the virus from spreading further. Because of the importance of information, education and knowledge regarding HIV/AIDS, and in addition, the lack of previous research applying general knowledge management principles on wellness, this thesis takes on a Knowledge Management perspective. The thesis more specifically studies peer-to-peer approaches reflecting a theoretical process view and top-down approaches reflecting a theoretical element view when transferring HIV/AIDS related knowledge. Using a qualitative research approach, we analyzed three case companies in Johannesburg, South Africa through a triangulation method including interviews, statistics and corporate documents. Based on the insights of the analysis, we found indications that the two approaches and reflecting theoretical views on Knowledge Management has to be applied in unison and furthermore that the specific company context is a crucial denominator in the success of the knowledge transfer process. This thesis contributes to theory by providing a description of how the HIV/AIDS related knowledge is shared, stored and used within and beyond the borders of the three case companies. In addition, it provides a description of how the company specific contexts affect the perceived intermediate outcome and performance of the knowledge transfer approaches and reflecting theoretical views. Finally, this thesis increases the understanding of how the knowledge transfer, given the specific company contexts, can be improved and further holds essential implications for theory and management practice.

Keywords: Knowledge Transfer, Element View, Process View, South Africa, HIV & AIDS

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1.0 Introduction

1.1 Taking responsibility for the global working life

"Globalization has opened up the world, spread knowledge and technologies, and lifted hundreds of millions of people out of poverty over the past few decades. But true globalization rests on the idea of sharing. We share a planet, we share a global economy, and we increasingly share a global labor market. For this reason, we also share the task of finally taking responsibility for global working life."

- Prime Minister Stefan Löfven at The ECOSOC Session
New York, USA 30 mars 2015

In a world that is continuously changing, it is crucial to facilitate the development of society in a direction that both people, companies and societies can thrive in. It is further a necessity for companies operating in emerging countries to create an understanding of local culture, relationships and business structures in order to make a positive change. The urgency of taking responsibility, not only for the business itself but also for the societies in which it operates is debated globally. Not least in Sweden, through the initiative "The Global Deal" presented by the Social Democracy party in 2015. The core of the "Global Deal" is the concept of shared responsibility between all stakeholders in the global workplace arena, with the aim of creating real win-win-win situations. The Swedish Prime Minister, Stefan Löfven, stated the following during his speech at The ECOSOC Sessions in New York last year;

"What I hope can be developed is a new global concept, where various stakeholders can see the benefits of joining forces to promote joint solutions, while still representing their different interests."

- Prime Minister Stefan Löfven,
New York, USA 30 mars 2015

1.2 The threat of HIV/AIDS

One initiative that grew from the idea of responsible global working life is the Swedish Workplace HIV and AIDS Programme (SWHAP). It was founded in 2004 by the International Council of Swedish Industry (NIR) and Swedish Industrial and Metal workers Union (IF Metall) with the aim of implementing a long-term strategy in order to execute or support, HIV/AIDS Workplace Wellness Programs at Swedish related workplaces in Sub-Saharan Africa (SWHAP, 2016).

Ever since the first case of AIDS was reported in the early 80's, the HIV and AIDS pandemic has had dreadful humanitarian consequences with enormous effects on households, businesses and societies at large. More than 25 million people have died of AIDS worldwide, and another 36.9 million are currently living with HIV/AIDS. Although cases have been reported in almost all areas around the world, 97% of

people living with HIV reside in low and middle-income countries, particularly Sub-Saharan Africa. South Africa has one of the largest populations of HIV-infected individuals, with almost 20% of adults aged 15–49 years being HIV-positive (Young et al., 2010). The virus is consequently most prevalent among those of working age, implying that HIV/AIDS inevitably has become a critical issue in South African workplaces.

In 2010, research foresaw HIV/AIDS to be one of the biggest threats to the general business climate and the profitability of companies in Africa (ILO, 2010).

The virus thus affects both individual workers, companies as well as the labour market as a whole. This is particularly evident in form of decreased productivity and weakened workforce due to higher levels of sick leaves, mortality rate and low motivation (Halling et al., 2002). This makes the workplace, management, employees and trade union representatives' essential players in preventing the virus from spreading further (SWHAP, 2012).

Some attempts to manage the HIV/AIDS virus in the workplace have been initiated by institutional frameworks. South Africa has for example legislations that prohibits medical schemes differentiating benefits based on HIV/AIDS status. They states that all medical aid scheme benefits must include HIV/AIDS testing, care and treatment (Newenham-Kahindi et al,. 2013). However, across Africa in general, extensive legislation is still uncommon and there is a general agreement that the private sector is one of the best placed institutions to make a significant positive contribution towards improving social, economic and environmental conditions in Africa (IBLF & WBCSD, 2004; Nelson & Prescott, 2003). The opportunity of the workplace as an ideal arena to address the causes and implications of HIV/AIDS has been seized by SWHAP. They have put together a so called Wellness Program which aim to prevent the disease from spreading further by transferring wellness and HIV related knowledge in Swedish Workplaces in South Africa. The program is an example of how management, employees and trade unions together can contribute to interventions that save lives and secure future markets (SWHAP, 2012).

1.4 Problem Area

Handling HIV/AIDS in South African workplaces is a highly complex issue. First of all, HIV as a disease has been denied for centuries to the point where it today is stigmatized. Only a fraction of South Africans at risk for HIV have undergone voluntary counseling and testing, resulting in a situation where many South Africans are unaware of their HIV status. Stigmatization has further reduced people's willingness to engage in treatment and prevention, which further spreads the virus (Young et al., 2010).

HIV/AIDS denial had for example a significant negative impact during the presidency of Thabo Mbeki as recent as 2008, when he publicly denied that HIV causes AIDS. During his presidency, Mbeki instituted policies denying antiretroviral drugs to AIDS patients, describing them as "poisons" and furthermore instead promoted the use of unproven herbal remedies to treat AIDS. These policies have been blamed for the preventable deaths of between 343 000 and 365 000 people in South Africa (UNAIDS, 2000).

Another critical issue that has been recognized as having big negative influence on the HIV epidemic in

Southern Africa, is the gender inequality (UNAIDS, 2000). The relationship between men and women in South Africa many times translates into a power imbalance in sexual interactions, which increases vulnerability to HIV. For women, social norms defining everything from their acceptable behavior, characteristics, responsibilities and economic dependency often put them in vulnerable positions.

1.4.1 The importance of information and knowledge

The above described stigma and gender inequality concerning HIV/AIDS in South Africa makes the information spread regarding HIV a critical denominator in driving successful HIV/AIDS Wellness Programs (Birkoff & Körner, 1994).

> "Information and education about how to protect oneself are the only alternative to reduce the spread as it is impossible to stop or cure AIDS medically" (Birkoff and Körner, 1994).

Because of the importance of information, education and knowledge regarding HIV/AIDS, this thesis will take on a Knowledge Management (KM) perspective of the Wellness Programs run by SWHAP. The relevance of this particular focus is strengthen by Chang & Serwadda (2013) who states that up until now, significant attention has been directed at *what* should make up a package of HIV/AIDS preventive interventions, and that there has been less discussion of *how* these should be implemented, i.e. what strategies that are needed to achieve the goal of controlling the virus.

Research has furthermore addressed the subject of knowledge as that which directly guides the human action (Gruber et al., 1989). This implies that HIV/AIDS related knowledge is a prerequisite for triggering behavioral change in terms of both using condoms and/or taking an HIV-tests, which in the end are the most important factors in preventing the disease from spreading.

It is however important to recognize that knowledge regarding how HIV/AIDS is spread and treated is not in itself a definite mediator of peoples changed behavior. People can in fact be very knowledgeable regarding HIV and AIDS without changing their behavior accordingly. There are many factors other than knowledge, that have an impact on how and why people behave in certain ways. History, culture, tradition, religion and gender inequality are examples of other factors that could hinder change in behavior even if a successful knowledge transfer occurs. Nevertheless, as research has concluded, knowledge is an important prerequisite for behavioral change (Birkoff & Körner, 1994) it is a subject that is both relevant and interesting to investigate further.

1.4.2 HIV/AIDS Wellness Programs as a mediator of knowledge

The Wellness Programs that SWHAP implement often takes one of two strategic approaches to transferring HIV/AIDS related knowledge, a "peer-to-peer" and/or a "top-down" approach.

The peer-to-peer approach refers to the spreading of HIV/AIDS related knowledge through Peer-Educators in organizations. Simply put, the Wellness Program makes use of Peer-Educators i.e. employees

of the same societal group or social standing when spreading knowledge within the organization (Liverpool VCT, care and treatment, 2009). This approach has many benefits. Wingood and DiClemente (1996) have for example noted that Peer-Educators can be a more credible source of information, may communicate in a more understandable language and also serve as positive role models.

> Peer-Educators can overcome cultural obstacles and easier find the most appropriate and realistic risk-reduction strategies from experience (UNAIDS, 2016).

However, despite the previous success of this approach, Peer-Educators should not be regarded as the answer to positive results with respect to HIV/AIDS interventions. Programs may fall victim to such factors as too much expectation, inadequate planning, improperly trained Peer-Educators and intergroup relations that are characterized by feelings of jealousy and competitiveness (Hope, 2010).

The alternative approach can be referred to as the "top-down" approach, which means that the company does not educate any Peer-Educators amongst their employees. Instead, the management team, often the HR-department controls all of the wellness related information and is furthermore in charge of what, how often and how the information is distributed.

It is plausible to believe that these two approaches hold both advantages and disadvantages depending on what company context they are implemented in, and how the implementation and further support of the approaches play out. This sheds light on an interesting question regarding the perceived function of the two separate approaches to transferring HIV/AIDS related knowledge, given the fact that all companies provide different environments for them to either flourish or fail in.

1.5 The purpose of the study

The purpose of this thesis is to investigate how the peer-to-peer and top-down approaches of transferring HIV/AIDS related knowledge within the Wellness Programs are perceived to work. We further wish to study this in relation to the specific contexts at three Swedish MNEs operating in Johannesburg, South Africa. Moreover, we will explore possible ways in which the transfer of knowledge within the Wellness Programs can be improved.

1.6 Limitations and Prerequisites

Before initiating the study, we prepared our work through extensive contact with SWHAP and their local wellness partner in South Africa, the Reality Wellness Group (RWG). During our meetings, we made sure to gather as much information as possible in regards to their work, the Wellness Programs and companies that we intended to investigate. Once on local ground we spent a day at RWG to familiarize with their work further and met with various people to discuss the HIV/AIDS Wellness Program. We also visited a Wellness Day organized by them to increase our understanding of the various services they provide on site. This enabled us to deepen our understanding of the companies and programs, which we intended to study beforehand and thus provided us with an opportunity to further, adopt our methodological work to local conditions before executing our interviews.

In terms of practical limitations, this thesis will only study three Swedish MNEs in Johannesburg, South Africa, during the specific time period of March 2016. Due to time restrictions, our study is restrained to three companies, 36 employees and four people who have been part of initiating the HIV/AIDS Wellness Programs that we intend to investigate. We furthermore do not have the possibility to, within the scope of this study, investigate how phenomena's such as gender imbalance and/or the stigma towards HIV in South Africa is affecting the results in this study.

We have chosen to focus on the field of Knowledge Management.

As the phenomenon that we are investigating plays out at the workplace, we believe that it is suitable to foremost find support for our empirical findings in the organizational management literature. We are well aware that the subject of HIV/AIDS is often handled and studied from a macro-economic perspective because of its significant negative effect on societies at large. However, with background in our problem area, we will not include any literature originating from this field.

It is further important to recognize that projects concerning health and wellness within organizations can be classified both as pure strategic business/management strategies (SWHAP, 2014/2015), as well as CSR-initiatives depending on the environment in which they are implemented. We would like to argue, with support from theory that the Wellness Program in a Western setting belongs to the CSR field. Whilst, in a less developed country (LDC) context, the question of HIV/AIDS is rather viewed as a strategic issue as the MNEs in these countries cannot succeed in societies that fail (Eweje, 2006 & Visser, 2003).

As the study was performed in South Africa, Johannesburg, in a LDC context, we will in this thesis treat the subject from a general strategic perspective. Consequently, the chosen theoretical framework that will be presented later is based on strategic KM principles and will not incorporate literature derived from the field of CSR.

Our prerequisites and limitations will significantly limit the scope of the thesis, its results and finding.

1.7 Expected contribution

Taking into account the limitations and prerequisites of our study, the main expected contribution of this thesis is to increase the understanding of how the HIV/AIDS related knowledge is disseminated, transferred and used via the chosen approach within and beyond the borders of the three case companies in Johannesburg, South Africa. We further wish to contribute to a better understanding of how the company specific contexts affect how the knowledge transfer processes within the Wellness Program play out.

The ultimate goal is to generate both theoretical and managerial implications. On a theoretical level we wish to contribute to a better and broader understanding of knowledge transfer and furthermore implications for future studies within the field of KM. On a managerial and theoretical level we wish to contribute to a better and broader understanding of how the knowledge transfer processes are perceived to work given different company contexts. Finally, in terms of solely managerial implications we wish to provide guidelines as to how the knowledge transfer processes within the Wellness Program are likely to be improved in the future.

1.8 Thesis Disposition

This thesis is divided into *seven* chapters, including: Introduction and Background, Theory, Methodology, Empirics, Analysis, Concluding Discussion and Implications. In this *first* chapter we have introduced the background and starting point of our study and why HIV/AIDS related knowledge transfer within Wellness Programs are an important and relevant subject to study. In the *second* chapter, we provide a review of previous research within the field of KM, including a presentation of our problem formulations and how they are linked to theory. The third methodological chapter follows the theoretical chapter. This includes an outlay of the research method used to gain the primary and secondary empirics of our study. We further present an overview of the most important primary and secondary data in the *fourth* chapter, the empirics. The empirical findings will then be analysed in chapter *five* to provide answers to the problem formulations of the study. The main results will then be presented in the *sixth* chapter, called the concluding discussion. Finally, we will present managerial and theoretical implications, as well as methodical reflections, and suggestions of future research within the field of KM in chapter *seven*.

Fig. 1 Disposition of thesis

2.0 Theoretical framework

This second chapter provides an overview of the theoretical framework used to perform this study of the Wellness Programs in the three case companies. It first provides a more comprehensive definition of the concept of knowledge, and then handles the management of knowledge in general and more specifically in an organizational context. Finally, it presents the various processes behind knowledge transfer and the factors enabling them, which provides the core focus of our study. In a final section the different theoretical contributions are put together in a theoretical research framework.

2.1 Information vs. Knowledge

The definition of knowledge can be described as a "justified true belief" (Nonaka, 1994). Further, "information" is often used interchangeably with "knowledge", but there is in fact a clear difference between the two terms. “Information” is more of a flow of meanings or messages, which can both add to, restructure and change “knowledge” (Machlup et al., 1983). This fact further highlights an important factor of knowledge related to *human action*. To give one example, Gruber (1989) discussed the subject of an expert's "strategic knowledge" as a type of knowledge that has a direct effect on the expert’s action. Nonaka (1994) supports this belief and likewise come to the conclusion that action is closely related to “what we know”.

However, there has been a lot more research regarding how knowledge and information relates. One important finding is that information can have both semantic and syntactic perspectives (Shannon and Weaver, 1949).

> “The syntactic aspect of information can be illustrated by the volume of information, which is measured without regard to its meaning or value. The semantic aspects of information are centered on the meaning of that information” (Shannon & Weaver, 1979).

For knowledge creation to occur, the semantic aspects of information is more important as it centres around conveying meaning to the information. Information, seen from the semantic standpoint therefore reveals that it incorporates new meaning which is not the case with syntactic aspects of information (Bateson, 1979).

2.2 Tacit & Explicit Knowledge

Theory usually talks about two kinds of knowledge, tacit and explicit knowledge. Knowledge that is technical or academic data/information described in formal language can be referred to as explicit knowledge Eg. manuals, copyright and patents or mathematical expressions (Smith, 2001).

Explicit knowledge, to its nature, is easy to reuse in various situations. In terms of gathering and using this

type of knowledge a relatively stable and predictable environment is necessary (Smith, 2001).

Whereas explicit knowledge, is the "know what", tacit knowledge can be categorized as more practical and action-oriented "know how". Tacit knowledge often originates from personal experience and practice. The tacit knowledge is seldom expressed openly, it is rather automatic and requires minimum time and thought. In an organisational environment it influences the behaviour of employees and often defines how decisions are made (Liebowitz and Beckman, 1998). In contrast to explicit knowledge, tacit knowledge is not found in manuals, files, books or databases. It is much more local and generally come from face-to-face contacts (Smith, 2001).

2.2.1 The relationship between explicit and tacit knowledge

It has been found by numerous researchers that tacit knowledge can be converted to explicit knowledge and vice versa. Every organization handles explicit and tacit knowledge in its unique way. Many factors influence the effort and time devoted to the pursuit of explicit and tacit knowledge. Cooperation and trust are essential for the transformation from explicit to tacit knowledge to occur (Smith, 2001).

Nonaka (1991) suggests four basic patterns for knowledge creation in organizations where explicit and tacit knowledge interact in various patterns. However as Smith (2001) claims, it is nearly impossible to know where or when tacit knowledge emerge. Tacit knowledge simply ''is'', it knows no direction or boundaries (Smith, 2001).

For the purpose of this study, we will only take into account that tacit and explicit knowledge co-exists and that they affect each other. In other words, we will not have the opportunity to look into how, when and where the transfer between explicit and tacit knowledge occur.

2.3 The knowledge participants

Research has shown, that within the market for knowledge two main participants occurs; on the one hand, individuals that supply knowledge and on the other hand, individuals that demand it. Since the research regarding the knowledge participants is extensive, there are furthermore also numerous ways of referring to the participants even though the basic idea remains the same (Lin et al., 2005). To give a few examples, sender and receiver (Lin et al., 2005), supplier and user (Vining, 2003), recipient and donor (Easterby-Smith et al., 2008). In our study, we will use the terms sender and receiver by Lin et al. (2005). The sender is an individual that has knowledge that can be of interest for the receiver (Davenport & Prusak, 1998; Vining, 2003; Lin et al., 2005). The sender is either the Peer-Educator or the Manager sharing wellness related information while the receiver is typically an employee in this particular study.

It is important to remember that both the sender and receiver of information need to be active in order for an information transfer to occur (Davenport & Prusak, 1998).

Since it is impossible to know the value of a knowledge transfer in advance, the engagement of both parties is fully dependent on their expectations on the transfer. The expectations are usually affected by available information concerning: the type of knowledge, the senders level of competence, the context, the consistency between the participants' and finally, the relationship between the two (Lin et al., 2005).

However, the quality of available information can be unbalanced between the sender and receiver, which in turn influence the perceived profit of engaging in the transfer (Vining, 2003).

A common phenomenon in literature concerning knowledge participants, is "the absorptive capacity" which refers to the receiver's ability to value, assimilate and apply new knowledge (Cohen & Levinthal, 1990; 25 Szulanski, 1996; Bakker et al., 2011). Over all, the absorptive capacity depends on the degree of prior related knowledge which means that lack of knowledge sometimes is the reason why knowledge transfers does not take place (Cohen & Levinthal, 1990; Szulanski, 1996). However, in order for a transfer to occur, the absorptive capacity also emphasizes the importance of the senders ability to understand the value of the knowledge, this is called the sender's motivation (Easterby-Smith et al., 2008).

Studies have found that these concepts have an important part in improving intra-organizational knowledge transfer (Szulanski, 1996; Gupta & Govindarajan, 2000) which is furthermore why they are relevant concepts to discuss within the frame of our study of Wellness Programs in companies.

2.4 Knowledge in companies

Organisations are highly dependent on information that is actionable and that adds value, ie. knowledge (McConalogue, 1999). For knowledge to create real value in an organisation it is important that it is focused around strategic priorities and that it matches the core values and mission of the company (Smith, 2001). Managing and foremost understanding knowledge in an organisation is an extremely complex task. This is further why an increasing number of companies started to implement KM as an integrated part of their operations in the beginning of the 21st century (Al-Ghassani et al., 2004).

2.5 Knowledge management

A simple definition of KM is "a systematic process of capturing, transferring, and sharing knowledge to add competitive value (Drucker, 1993; Hjertzen & Toll, 1999; Scarbrough & Swan, 1999; Skyrme & Amidon, 1997) and to improve performance (Robinson et al., 2001)".

Related to our study of Wellness Programs, KM is critical as employees falling ill have severe effects on their working capacity and thus the effectiveness and efficiency of how the business is run. Which in the long run might have a negative effect on the overall business performance of the companies comprised by this study.

Researchers have suggested three major components for KM in earlier comparative studies for KM frameworks. (1) KM enablers, (2) KM processes (3) Organizational performance (Beckman,

1999; Hedlund, 1994; Holsapple & Joshi, 1999; Lai & Chu, 2000).

The link between the three components can be understood through the input-process-output model, suggested by Hackerman & Morris (1978). This model is useful to illustrate how various input factors affect performances through some kind of interaction process. It showcases that KM enablers affect organizational performance through KM processes. However, to establish the relationship between them Davenport (1999) stresses the importance of a fourth component for KM, namely the **(4) intermediate measures** (Davenport, 1999).

These four components were put together in an empirical research model by Lee & Choi in 2003, enabling them to successfully study the relationship between the different components. For that reason these four components have also been chosen to make up the foundation of our empirical research model which we will explain in depth in section 2.6. Each component will be elaborated on in closer detail below.

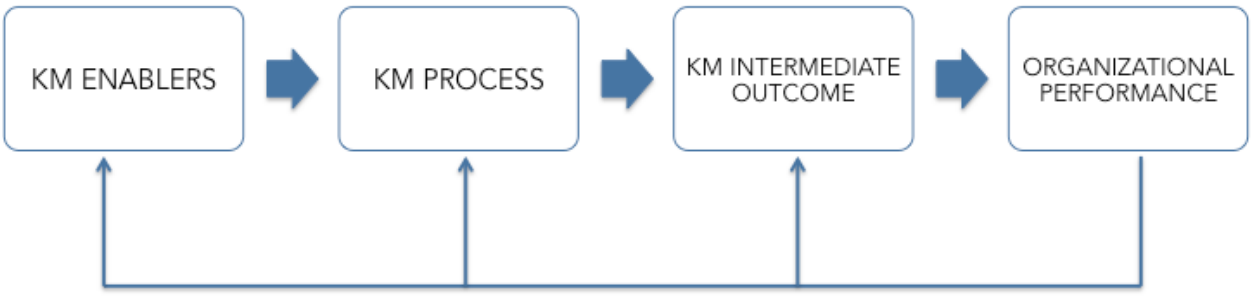


Fig. 2 Foundation of Research Framework in KM

2.5.1 Knowledge Management Enablers

KM enablers has its origins in theory derived from socio-technical research. It claims that an organization and its work system are constructed by two independent but correlative interacting systems (Bostrom & Heinen, 1977).

- The technical system comprises processes, tasks, and technology (Bostrom & Heinen, 1977).
- The social system includes characteristics of people and relationships among them, authority structures and reward systems. In our study, organizational structure, organizational culture and people are considered a part of the social system and is furthermore the system that we will focus on (Bostrom & Heinen, 1977).

Organizational structure: According to Hedlund (1998), KM is related to organizational structure. Centralization and formalization are two of the most profound dimensions of structural frameworks. Formalization describes the degree to which working relationships and decisions are governed by standard policies and formal rules (Rapert et al., 1998). Centralization is concerned with the locus of control and

decision power within an organization (Walker & Ruckert, 1987).

In an organizational environment, characterized by instability, it is important to have numerous sources of information, different interpretations of information, and to include several perspectives. Adding variety, expands the range of organizational activities and therefore increase the possibility of developing organizational knowledge (Ichijo et al., 1998). When an organization supports variation in process and structure it can more easily adjust when unexpected problems arise (Nevis et al., 1995).

In our study, we aim to understand the organizational structure of the three case companies through investigating the use of policies, rules, formal standards and hierarchies as well as the locus of power.

Organizational Culture: Many researchers have found culture to be the most important determinant of success of KM (Davenport et al., 1998; Nonaka & Takeuchi, 1995; Demarest 1997; O'Dell & Grayson 1998). However, it is the most ignored variable which has made cultural issues the number one reason for complications in regards to KM.

Organizational culture should have several components enabling the transfer of knowledge: (1) People have a positive attitude to knowledge, (2) People are not hesitant to share knowledge, (3) The existing culture matches the KM project (Davenport et al., 1998). These factors will therefore be investigated in our study.

Speaking of cultural factors, the value of "care" within organizational relationships is another important factor. "Care" describes the interaction between receivers and providers in an organisation. It illustrates the quality of a relationship rather than the quality of functions or roles. The concept of "care" incorporates real collaboration, learning, mutual trust and development (Ichijo et al., 1998; Krogh, 1998). These will, in addition to the above stated cultural parameters, also be examined within the frame of our study.

People in the organization: As mentioned above, many researchers consider collaboration as a crucial factor in knowledge creation or sharing processes. Scott and Bruce (1994) defined collaboration as the degree of active support and help amongst people in a group. They insisted that collaboration is important as it encourages new ideas and a higher level of risk taking that comes from an increased openness and reduction of fear.

Besides collaboration, trust, is another facilitating parameter in learning. Trust is defined as a reciprocal faith in others' intentions and behaviours (Kreitner & Kinicki, 1992). Decisions made through the exchange of knowledge under certain conditions are based on trust (Huemer et al., 1998) and is moreover highly important in cross-functional or inter-organizational teams (Hedlund, 1994).

Lastly, focusing on individual learning and development in an organization increases idea generation which is also critical for successful KM and knowledge transfer (Damanpour (1991); Hurley (1995), Katz & Tushman (1981).

In our thesis we aim to study the enabling factor of "people" through investigating level of fear, risk taking, trust and focus on individual learning within all case companies.

2.5.2 Knowledge Management Processes

Numerous researchers have identified different KM processes and ultimately suggested a common KM process including creating, sharing, storing and using knowledge (Demarest, 1997; Nonaka & Takeuchi, 1995; Wiig, 1995; Lee and Choi, 2003). This is furthermore the foundation that we intend to use in order to study the processes of transferring HIV/AIDS related knowledge in this thesis. We have chosen to not treat the first part concerning creation of knowledge in isolation, as it is not possible to determine when, where and how knowledge is actually created in the organizations that we aim to study. We will look at the creation of knowledge as an overarching occurrence taking place in all steps of the process of sharing, storing and using knowledge.

Moreover, we aim to study the KM process through the lens of two related but different views on KM, the "process view" and the "element view" proposed by Preuss & Cordoba-Pachoni (2009). To a great extent, these views reflect earlier work of Newell et al., (2001) and Scarbrough (1996), who presented a static perspective of the elements needed to facilitate knowledge capture, and a dynamic view of the processes that lead to effective knowledge revitalisation and use. The two views will be further elaborated on below.

2.5.2.1 Element view of knowledge

In the static element view, knowledge is seen as a resource aimed to enable storage and maintenance of information, usually as an electronic resource. Supporting elements could provide connectivity and capture the information, but with a weak role for individuals in the organisation. There is a clear separation of tasks in this view, where decisions are made at the top and then disseminated to lower levels (Jackson, 2005; Morgan, 1997; Nonaka and Takeuchi, 1995).

In the element view, knowledge is mainly of value for people operating at the top of the organisation. The information is usually captured in documents where focus is on keeping and protecting knowledge as a strategic asset. Companies in the element view mainly share performance related information and often create databases for core activities (Preuss & Cordoba-Pachoni, 2009). One potential risk in this view is that the organisations close their boundaries to external influence in order to uphold a specific niche of competitive advantage (Liebeskind, 1996).

In our study, the top-down approach to transferring HIV/AIDS related knowledge within the

Wellness Programs resembles the element view of knowledge.

2.5.2.2 The process view of knowledge

The process view on the other hand, has a more dynamic view on knowledge and points out the importance of the individual as a source of innovation and knowledge in the organization (Checkland, 1981; Nonaka, 1994; Nonaka and Takeuchi, 1995). The process view further sees the organization as a living organism that continuously develops in contact with its environment (Morgan, 1997). In order to enable a process view of knowledge, the organization needs a flat and flexible structure (Nonaka and Takeuchi, 1995) with employees that share collective feel for the organizations mission, vision and impact on the external environment. The organization thereby turns into a place where individuals keep expressing their tacit knowledge in interactions with others (Nonaka and Takeuchi, 1995; Wenger et al., 2002).

The process view of KM further highlights the importance of socialization in work groups inside the firm to exchange knowledge which can further support the stakeholder dialogues (Pedersen, 2006; Roloff, 2008).

The process view moreover differs from the element view in regards to distribution of decision-making authority since it de-centralizes and co-locates the decision-making in the organization (Nonaka & Takeuchi, 1995; Grant, 1997). A key component is the identification, nurturing and fostering of communities of practice in order to never stop rethinking and improving the nature of the activities in the organization. The importance of self-reflection on for example societal topics can thereby stimulate interests in other issues related to the role of the organization in society. This could for example mean that managers pair their focus on short-term goals (e.g. market share and revenue) with a focus on satisfying long term needs for employees and society at large (Preuss & Cordoba-Pachoni, 2009).

In our study, the peer-to-peer approach to transferring HIV/AIDS related knowledge within the Wellness Programs resembles the process view of knowledge.

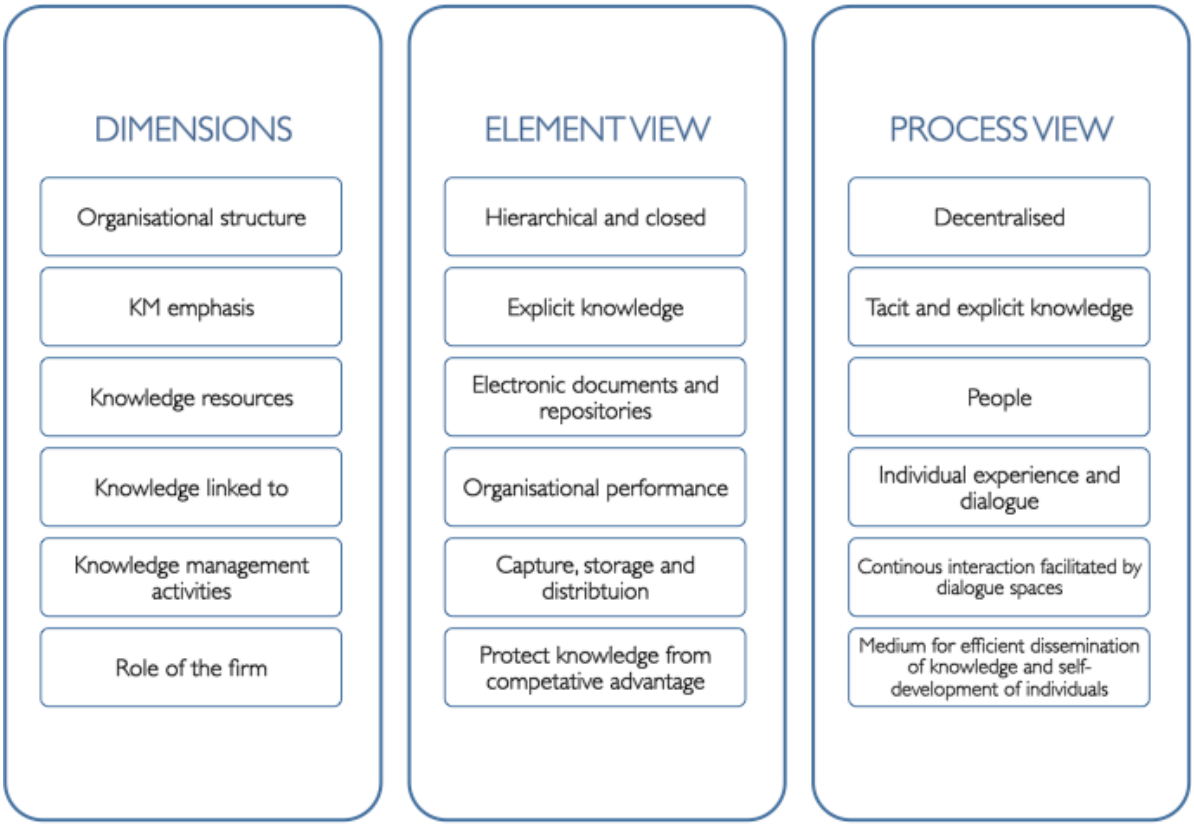


Fig. 3 Overview of Element & Process view

Never the less, two views of KM must not be treated as ideal types since organizations in reality often presents a combination of the two. As outlined in Figure 3, the two approaches have different qualities, but at the same time, they influence each other. However, the separation of the two views enables for practical implications to be drawn for organizations that adopt one or both of the perspectives (Preuss & Cordoba-Pachoni, 2009).

2.5.3 Knowledge Management Intermediate Outcome

Research has shown the intermediate outcome to reflect one facet of an organization's performance. This can result in improved financial and nonfinancial results (Davenport et al., 1998) like knowledge worker capability which is a requirement for a successful organizational performance. Numerous researchers have stated that knowledge creation relates to benefits in terms of intellectual capital of an organization (knowledge, skills and processes) which in turn has a positive impact on business performance (Drew, 1997). In our study, we will measure knowledge worker capability by investigating the employees perceived attitudes and behavior in regards to the knowledge transfer process, as we would like to argue that this perception will influence the perceived performance in a final step.

2.5.4 Organizational Performance

Measuring an organizational performance can be very challenging and there is no optimal way to analyze its connection to KM (Drew, 1997). The measures of organizational performance can according to Drew (1997) be classified into four categories: (1) Financial measure (2) intellectual capital (3) balanced scorecard (4) tangible and intangible benefits.

Since our study does not have a financial focus, and because we do not have access to these numbers we have chosen to look at the intangible benefits derived from the Wellness Program within and beyond the borders of the three case companies. In order to investigate these we will look at statistics from SWHAP measuring:

(a) Percentage of employees attending an HCT-session.

(b) Percentage of employees that the peer educators have talked to internally and externally.

(c) Percentage of employees who have gone through training and thereby participated in the activities that the Wellness Program provides.

These three measures thus provide the foundation from which we will analyze the organizational performance of the three case companies.

2.6 Theoretical research framework

Taking the theoretical section above into consideration including the empirical research model framework by Lee and Choi (2003) we have created a theoretical research framework adjusted to our study below. The framework illustrate the different theoretical components of our research and furthermore what we intend to study in the three case companies.

(1) We first aim to define the company context in terms of structure, culture and people in all three case companies. The company context resembles KM enablers, which will enable for the transfer of HIV related knowledge to occur.

(2) Secondly, we aim to investigate how the two applied views of knowledge, the process view (illustrated via the peer-to-peer approach) and the element view (illustrated via the top-down approach) are perceived to work at the three case companies.

(3) The intermediate outcome of KM is in our study illustrated by the perceived attitudes and behaviors of the employees dependent on the chosen approach of transferring knowledge.

(4) Finally, we aim to study the perceived performance by considering statistics in regards to actual results of the KM processes.

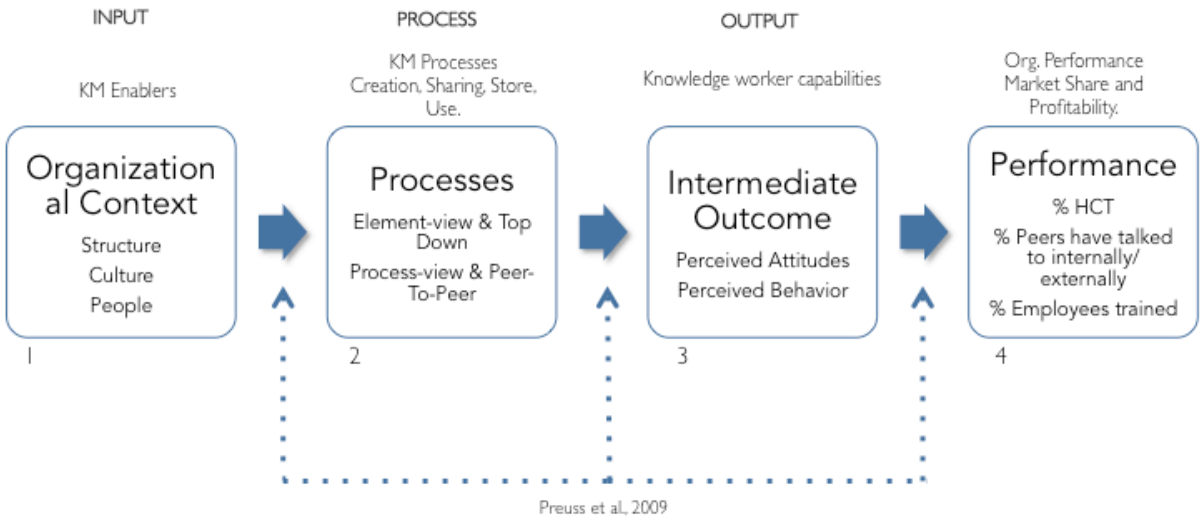


Fig. 4 Overview of Theoretical Model

2.7 Problem formulation

Based on the presented theoretical framework, and with the goal of fulfilling the purpose of the thesis we have created the following two problem formulations:

ONE: How is the HIV related knowledge transfer, in terms of sharing, storing and using knowledge, perceived to work within the Wellness Program in company A, B and C, given:

- **(a)** The choice of a peer-to-peer and/or top-down approach
- **(b)** The reflected element- and/or process view of knowledge
- **(c)** The company specific context in terms of structure, culture and people

TWO: What are likely ways of improving the transfer of HIV related knowledge, given the specific prerequisites (a-c).

Problem formulation **ONE** aim to increase the understanding of how the HIV related knowledge is shared, stored and used within the Wellness Programs via the **(a)** two KM approaches and **(b)** reflecting views, within and beyond the borders of the three case companies. Furthermore the aim is to understand how the **(c)** company specific contexts affect the perceived intermediate outcome and performance of the knowledge transfer process. Finally, problem formulation **TWO** aim to increase the understanding of how the knowledge transfers, given the chosen approach, reflecting view and specific company contexts can be improved.

3.0 Method

This following chapter provides a description of the chosen research method used in this study. Included in this chapter is the research design we have chosen, a description of how and why the cases were selected, and further how data was collected and analyzed. Finally, a discussion regarding the limitations of the method used and the study's validity, reliability, objectivity, credibility, transferability and dependability is presented.

3.1 Research Design

We have chosen to use a deductive approach to our chosen field of study. The reason is that KM, our main theoretical focus, is a frequently studied area within the organizational management literature (Lee & Choi, 2003). The deductive approach will therefore enable us to create an initial understanding of how different views on knowledge transfer processes play out in numerous companies. It will further allow us to make inferences in regards to the chosen case companies before gathering empirical data. This will allow us to analyse how our findings relate and does not relate to prior research in the same field (Jacobsen, 2002).

However, the deductive approach involves one negative aspect since it can make us unconsciously search for information that pair our personal opinion in regards to what is relevant to our specific problematization and data collection. We have tried to prevent this through being observant of this risk from the start (Jacobsen, 2002).

We chose to conduct in-depth interviews with employees at the chosen case companies as well as people from facilitative and supportive third party organisations connected to the Wellness Program, namely SWHAP and The Reality Wellness Group.

We consider the output from the interviews as our primary source of data, which means that the chosen research design is qualitative to its nature. According to Malhotra (2004), interviewing professionals is likely to be a desirable method with the purpose of describing and understanding complex behaviours, which is the case in this study and thesis.

3.1.1 Triangulation

As recommended by Yin (2014), we used methodological triangulation to support our data and analysis. In the case of our thesis, triangulating meant using statistics and corporate documents in addition to the empirical findings gathered through in-depth interviews. According to Bryman and Bell (2007) triangulation strengthens both the validity and reliability of the study.

3.2 Research Method

3.2.1 Qualitative Research & Case Study

In order to answer the describing purpose of our study, we have chosen the qualitative research method. This method intend to study events in their natural setting, by trying to identify the occasions in terms of the meaning people bring to them. By choosing this method, we intend to gain a deeper understanding of the knowledge transfer processes within the Wellness Programs (Firestone, 1987).

Further, qualitative data is a strong method to use when the goal is to understand processes in terms of their ability to capture evolving phenomenon in detail, which is hard to do with quantitative research and data (Langley, 1999).

With support from the purpose of this thesis, we have further chosen to make the qualitative study in the form of a case study. The goal with a case study is to examine an event in rich detail in order to draw conclusions regarding an event in its particular context. This means that when we perform the case study we focus on the exploration of the particular case companies and their contexts rather than a generalization (Denzin & Lincoln 2005).

Yin (2014) further argues that the case study design is to prefer when 'how' and 'why' questions are presented, when the researcher has limited control, and when focus is on a temporary phenomenon in real-life context", which applies to our study of KM in Wellness Programs. According to Eisenhardt (1989), a multiple case design is to prefer over a single case design, which is why we chose this method. Multiple cases means multiple experiments in a quantitative study meaning that the more cases that can be arranged to establish or re-think a theory, the stronger the research turns out. However, the cases need to be selected carefully in order to either produce similar results i.e litheral replication, or contrasting results i.e. theoretical replication (Eisenhardt, 1989).

3.2.1.1 Case Selection

When choosing our case companies our ambition was to generate theoretical replication, which means that our study tests two established theoretical concepts, the element and process view (Eisenhardt, 1989). These concepts are contrasting towards each other, but also coexist in some ways. The three case companies were chosen based on their different approaches to operating the Wellness Program, where it was expected that one would make use of solely the peer-to-peer approach reflecting a process view. One would make use of a strict top-down approach reflecting an element view. And finally, the third one was expected to display a mix between the two approaches and consequently reflecting both views.

3.2.2 Secondary Data

Two vital components of the applied triangulation consist of secondary data in terms of statistics and corporate documents from SWHAP. SWHAP launched its first program in 2004, and the organization has

ever since collected data on the outcome and results of the program. The data is today presented both via actual statistics including various KPI's on outcomes of the program, and corporate documents that provides a better understanding for, and background to, the way in which the program is run in the three different case companies. The main reason for using the corporate documents was to create a better understanding of the programs in prior to our own investigations, and further the statistics to create a better and broader view of our findings after performing our interviews.

3.2.2.1 Corporate Documents

SWHAP has provided us with various corporate documents regarding the organization as such, and the programs and activities in Johannesburg, South Africa more specifically. By spending a lot of time and effort to read about the programs in case company A, B and C we were able to get a better understanding of the reasons behind the implementations and the success of the programs in prior to performing our own study. The corporate documents furthermore helped us to prepare our study and gave us an initial understanding for what we were about to investigate further. The authors of the corporate documents were SWHAP employees in Sweden and South Africa and we have used documents in both hard copy and online dated from 2010-2015.

3.2.2.2 Statistics

The other important secondary data set that SWHAP has provided us with, are the statistics of the performance of the programs. The data incorporates various KPI's said to measure the effectiveness of the program. The statistics has in contrary to the corporate documents mostly provided us with a broader and better understanding of the performance of the programs and has been used to validate or support our empirical findings. In detail, we looked at the perceived performance of the following numbers from 2015; Employees trained, Completed HCT, Condoms distributed, Number of employees the Peer-Educators had talked to, Number of people outside the organisation that the Peer-Educators had talked as well as a Percentage of the employees trained.

Because of the challenge with validity when using secondary data, it was important to ensure that we used reliable sources (Bryman & Bell, 2011). Before using the data provided by SWHAP, we evaluated the validity by investigating the writers' connection to the companies and the legitimacy of the people in charge of gathering the data. However it must be pointed out that SWHAP is a stakeholder that can be biased by own interests.

3.2.3 Primary Data

A significant part of our empirical study was based on in-depth interviews at the three case companies as well as interviews with SWHAP and their local wellness partner, The Reality Wellness Group. As Malhotra (2010) argues, conducting interviews is a method to prefer when the aim is to get many details and expert opinions on the study object.

From our interviews we hope to deepen our understanding of how the Wellness Programs actually work within the three case companies in South Africa. The interviews will further enable for us to analyze the credibility of the secondary data which mirrors the first two parts of our triangulation (Bryman & Bell, 2007).

3.2.3.1 Structure of interview

We used a semi-structured approach when conducting the interviews, since we found it to be a good way of gaining the in-depth information required to fulfill the purpose of our study. This means that we had put together an interview guide beforehand where our questions functioned as guidelines. This gave the respondent an opportunity to answers beyond the boarders of the formulated questions and we could have more of a discussion setting. The interview object was further able to answer more spontaneously which was good for the describing objective of our study. We could also easily ask follow up questions whenever necessary which further limited the risk of forgetting or talk around important subjects (Buchanan & Bryman 2009).

We found the semi-structured interview approach especially vital when talking about HIV/AIDS since many interview objects found the subject to be sensitive and highly personal.

The interview guide still provided us with stabilization between the interviews at the different organizations which enabled for us to organize our empirics and further analyze our findings in a structured way (Glaser & Strauss 1967*). (See appendix II and III for interview guides)*.

3.2.3.2 Procedure of Interview

Both of us participated in all interviews where one took lead on asking the questions while the other one took notes. According to Eisenhardt (1989), this is the most effective way of performing an interview. We began the interview by introducing ourselves and the purpose of our study. We further began with an open question concerning the employees general opinion regarding the Wellness Programs to bridge what we would discuss during the remainder of the interview.

The main parts of the interviews were conducted in the same way regardless of who we talked to. However, additional questions in regards to implementation, management and decision-making were posed to the managers and excluded in the employees interviews (Kvale, 1996).

We continuously ensured to inform the interview objects that all interviews were anonymous and that they did not have to answer any question they did not want to or feel comfortable with. We also offered them the opportunity to decide if it was OK if we recorded the interview or not. According to Kvale (1996) it is essential to ensure the ethical matters, such as confidentiality. We found the treatment of ethical issues vital in order to show our loyalty towards the respondents and at the same time, gain their trust. This made the respondents relaxed in the interview setting and further strengthened the validity of the given information.

Each interview was about 60 minutes and executed in English. All interviews were held face-to-face and tape recorded when OK with respondent. This to ensured that we got the right information and could focus on performing the interviews in a suitable way. Subsequently, the interviews were transcribed to text in order to contribute to the writing of the case study and/or analysis (Bryman & Bell, 2011).

3.2.3.3 Interview Subjects

All the interview subjects are considered particularly relevant for answering the problem formulation of the study. They are either managing, supporting or facilitating the HIV/AIDS Wellness Programs or participating in them as employees. The selection criterion was different depending on researched company profile. Within the companies using a top down approach we chose to talk to;

1. The person in charge for the program at the companies.
2. One of the managers part of the "project team group" (PTG) - The person/one of the persons in charge of communicating the information of the program. The "top-down catalyst".
3. One of the employees part of the "PTG"
4. One manager that is not part of the "PTG"
5. Four employees that is not part of the "PTG"

In the companies using the "peer-to-peer" approach there is no manager in charge of communicating HIV/AIDS related knowledge from the top down which is why this person is being replaced by the "peer" in these companies. The list of people interviewed in the "peer-to-peer" organisations is as follows:

1. The person in charge for the program at the companies.
2. One of the managers part of the "project team group" (PTG)
3. One of the employees part of the "PTG" - One of the "Peer-Educators".
4. One manager that is not part of the "PTG"
5. Four employees that is not part of the "PTG"

In the organizations showcasing a mix of the researched approaches to transferring HIV/AIDS Knowledge we talked to the following:

1. The person in charge for the program at the companies.
2. One of the managers part of the "project team group" (PTG)
3. One of the employees part of the "PTG" - One of the "Peer-Educators".
4. One manager that is not part of the "PTG"
5. Four employees that is not part of the "PTG"

3.2.4 Data Analysis

Throughout our study we recognized that our capabilities as researchers was critical in order for both the execution and the later analysis to be successful. In contrast to a questionnaire, the evidence to be gathered is defined as it is collected which is why a greater pressure is put on the researcher to be active in the process of a qualitative study (Rowley 2002).

Practically, this meant that we tried to our best ability to ask good questions, to listen and to interpret the answers carefully. We made this possible by having a good grip of the questions posed and also made sure to perform the study in a flexible and unbiased manner (Denzin and Lincoln 2005).

We analysed the three in-depth cases in two steps. First, we looked at each case on its own in order to get a comprehensive understanding of each particular case. We then compared the cases to find patterns and resemblances (Yin, 1981; Eisenhardt, 1989). This enabled for us to get a more complete picture of how knowledge is spread within the three case companies. We did this in accordance to the process of grounded theory proposed by Glaser and Strauss (1967), where data is coded into components. This made it possible for us to compare various components within each case, enabling us to find the patterns for answering the problem formulation (Eisenhardt, 1989).

3.2.5 Research Quality

Because of the different limitations, we will assess the research quality of our study in the following section. An appropriate way of doing that according to Yin (2014) is to look at the following core criterias of a case study research: (1) internal validity, (2) external validity, and (3) reliability. Lincoln and Guba (1985) further suggest that trustworthiness and authenticity should be examined. However, Bryman & Bell (2011) dismisses the authenticity criteria why we will only add the criterion of trustworthiness. This forth criterion consists of three pillars: credibility, transferability and dependability.

3.2.5.1 Validity

Validity refers to the importance of guaranteeing that the indicators used to demonstrate a concept are suitable for the scope and context of the study. The validity can be improved by using different methods of data collection. Validity is usually divided into internal validity and external validity (Bryman, 2004).

The internal validity describes the importance of ensuring that the interferences, instruments and variables used to prove a concept are appropriate to the context and the scope of the interview (Bernard, 2000). As we made use of foremost independent primary sources, ie. key people within the Wellness Program, we believe that the internal validity was strengthened.

The external validity refers to the probability that the information given corresponds to reality and can be generalized to other situations (Bernard, 2000). We recognize and agree with Bryman (2004) who further states that the external validity is hard to assess when conducting a qualitative study. Studies of this

character are often based on a limited number of research objects and samples, making it hard to apply the results of the study on a larger basis (Bryman, 2004). Nevertheless we attempted to raise the external validity by using multiple sources of information. We included statistics collected directly from the companies, as well as, interviews made with employees, managers, facilitative and supportive individuals (Bryman, 2004).

3.2.5.2 Reliability

Reliability ensures that consistent results may be reached when conducting the study another time (Bryman, 2004). By using control questions in our interviews we aimed to increase the level of reliability in our interviews. We asked the same question in various ways and also investigated both perceived behavior and attitude in relation to each given subject. Which according to the same researcher can help strengthen results and increase stability.

We further tried to augment reliability by recognizing potential barriers to answering derived from the language spoken. There a number of different languages in South Africa and most are fluent in English. However as misunderstandings and misinterpretations could be a problem, we framed our questions in several ways. This to make sure that the same areas were covered during the interviews, despite potential linguistic difficulties.

The HIV/AIDS stigma was a third challenge (UNAIDS, 2000). This because discussions relating to the topic is problematic, and may, also, affect peoples' willingness to give accurate and trustworthy information (Bryman, 2004). In order to milder the effect from social environment and circumstances we used a digital questionnaire when posing direct HIV and or sexual related questions.

As with the validity, it is difficult to secure the reliability in a qualitative study. Many times, different answers are given to the same questions, which, in a more quantitative study, would be a sign of low reliability. However, in a qualitative study this could be due to social environment and setting when conducting the interview (Bryman, 2004). This makes it crucial to analyze a qualitative study within its context which we continuously reminded ourselves of. However, despite all efforts we recognize that the outcome of a similar study at a later time might be different.

3.2.5.3 Objectivity

In line with Lincoln & Guba (1985), the objectivity of this study is demonstrated through avoiding personal values conflict with the collection and analysis of data. We constantly aimed to not ask leading questions, as well as, avoiding questions with yes or no answers. We started every interview on a general manner and then shifted towards asking more specific questions. We found it important to ask questions that gave the interviewee the opportunity to talk freely about a subject and therefore kept the questions as neutral as possible.

In addition, we intended to increase the objectivity by incorporating as many sources as possible to support our empirical data. We further tried to connect all finding to the existing theory.

Through interviewing employees who have no personal interest in the results of the research and study we believe that the objectivity increased even further. Moreover, we informed them that the purpose of our study was not to investigate whether the Wellness Programs are good or bad, but to investigate how they are perceived to work or not work in the organization specifically in regards to KM. We believe that this has contributed to reducing the lack of objectivity and bias related to also including SWHAP and managers.

3.2.5.4 Credibility

This criterion aim to assess whether the findings are believable and determine if the research gives a true picture of reality or not (Bryman & Bell, 2007). Since case studies are problematic in the sense of providing a whole picture (Yin, 2014) we decided to use different sub-methods to broaden the picture.

Firstly, participants were encouraged to speak freely around topics and later to expand on topics that they felt were important. This made it possible for us to take part of information that were not considered in the first place. We furthermore transcribed all interviews to avoid not recalling important bits of information (Merriam, 1994). In addition, the triangulation approach that we used made it possible to get a broader picture, enabling us to ground our findings on broader terms (Guba & Lincoln, 1985).

Despite all measures taken, some circumstances are uncontrollable. For example, the companies decided the actual setting of the interviews and thus out of our control. All interviews were performed in conference rooms at each company where the employee's work. This might have made them hesitant to express negative opinions in regards to the Wellness Program. Also the ethnical, cultural and social difference between the interviewees and us as interviewers was unavoidable and there is therefore a risk that these differences made some employees prone to not answer questions honestly. However, the most important factor with the greatest impact on the results credibility is the subject itself. Talking about health and HIV in particular is sensitive to its nature in any setting. We did try to take account to this fact by only discussing wellness in general in the interviews and by putting the actual HIV-related questions in an anonymous survey that the employees filled in digitally without us in the room. Even so, the sensitivity of the subject cannot be disregarded from as an obstacle to perfect credibility.

3.2.5.5 Transferability

Transferability investigates whether the results of this study are applicable in other contexts or not (Bryman & Bell, 2007). It is recognized that a case study does not have the possibility of being “statistically generalizable”. However, it provides possibility to provide so called “analytical generalizability” where the results can be generalized to the theory (Yin, 2014). We tried to enhance transferability thorough providing the reader with a “thorough description” of each case (Lincoln & Guba, 1985) and by using a multi-case method with the replication logic as recommended by Yin (2014).

3.2.5.6 Dependability

As Yin (2014) stated, dependability evaluates whether the research procedure is replicable by other researchers or not, and if the same outcomes would occur. To facilitate this, we gave a comprehensive description of the method used and further incorporated our interview guide with questions in appendix. We have also strived towards being as organized as possible throughout the whole research by saving all notes, versions and transcriptions in order to review and verify if needed. Bryman and Bell (2007) recommends these procedures as a method of improving the dependability.

3.2.5.7 Theoretical framework supported by methodology

The below figure clarifies of how our method corresponds to the chosen theoretical framework.

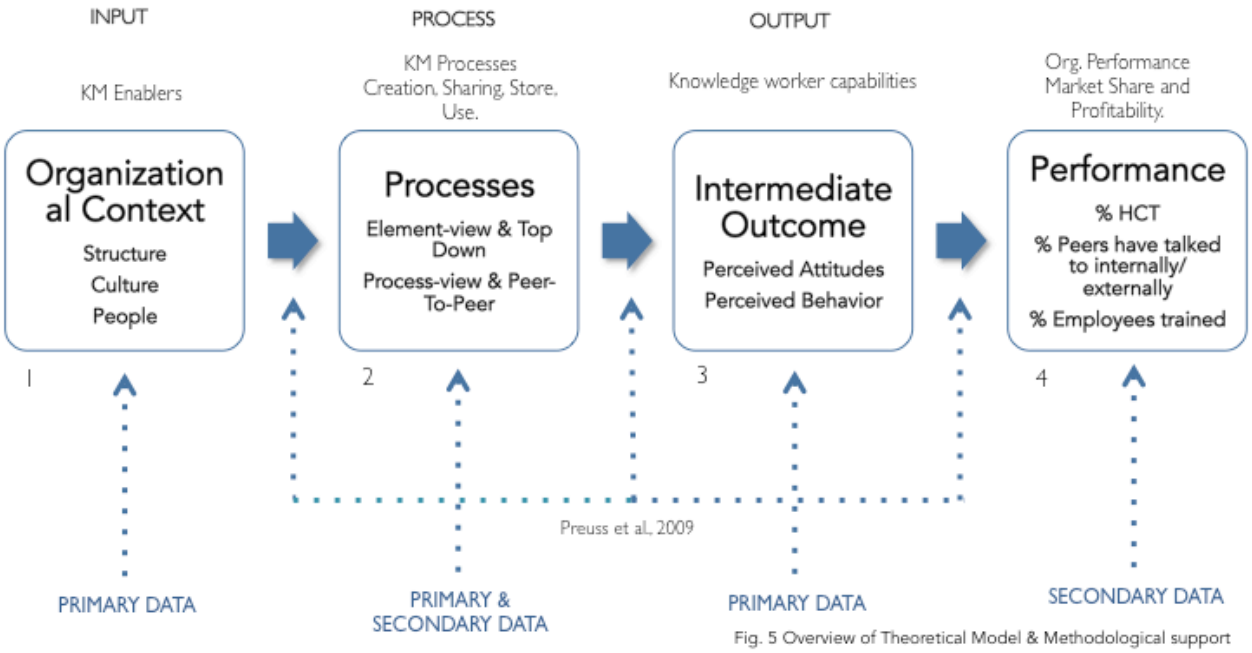


Fig. 5 Overview of Theoretical Model & Methodological support

4.0 Empirics

In the following section, the empirical findings from our study will be presented. We will start with presenting a review of the information extracted from the corporate documents, making up parts of our secondary data. Secondly, we will present the primary empirics gathered from our interviews with the responding employees at the three case companies. Third, we will present the second part of the secondary data in terms of perceived performance of the Wellness Program. Last, we will present at table with an overview of the most important empirical findings.

4.1 Secondary Data, Corporate Documents

4.1.1 The SWHAP Model

After reading the corporate documents provided by SWHAP, we were able to get a good initial understanding of the Wellness Programs from the perspective of SWHAP and RWG. We have summarized the most important findings below.

One initial piece of information that is important is that SWHAP helps its member companies to fund the rollout and the first three years in operation of the Wellness Program. In order to receive the funding of the Wellness Program, SWHAP demands that the companies sustain an HIV/AIDS policy, which ensures; confidentiality, disallows discrimination against HIV/AIDS-infected individuals and has a gender perspective. The goal is for the companies to, after the three years, see the benefits of the program, both financially and operationally and that they therefore will be willing to fund and manage the program themselves further on.

Through supporting companies and employees in HIV/AIDS affected regions, the Wellness Program aim to prevent further spread and negative effects derived by the virus. Both in terms of strategic issues in efficiency and effectiveness in the member organizations but also in terms of contributing to a more healthy society at large.

Managers and employees at the companies rolling out a Wellness Program generally form a Project Team Group (PTG) and work together with SWHAP in order to formulate and implement workplace policies and roll out the Wellness Program internally. The Wellness Program aim to encapsulate services within the following areas:

1. Information and awareness raising schemes for employees and employers
2. Creation of HIV and AIDS committee and policy
3. Voluntary counselling and testing (VCT)
4. Peer education training
5. Healthcare (nutrition, medication etc.)
6. Involvement of the employees' families

7. Community outreach activities and mentoring of other companies
8. Wellness Day at least once a year including information, voluntary testing and general wellness prognosis
9. Wellness related messaging at toilets updated each month
10. Distribution of condoms at toilets (SWHAP 2015)

It is important to point out that the Wellness Day (8) is a central activity within the Wellness Program as both SWHAP and the joining companies with support from RWG put a lot of time and effort into organizing and rolling out the day. The day provides an opportunity for all employees to get more wellness related information from various representatives and nurses, as well as take different health-and HIV tests. An important focus during the Wellness Day is for the employees to have fun and enjoy the day. A lot of the activities are rolled out in an enjoyable way, mixed with playful competitions and games. It furthermore has the ambition to minimize the stigma and denial towards HIV, by not treating the HIV information and testing in isolation, but rather roll out the day focusing on general Wellness where the HIV information/testing only consist of one part of the provided activities. The goal is for people to be less intimidated by this more general wellness approach, and consequently that more people will participate.

4.1.2 Partnership with the Reality Wellness Group

In South Africa, SWHAP has partnered with The Reality Wellness Group (RWG), who offers the following services:

1. On-site health risk assessments (HRAs)
2. HIV counselling & testing (HCT)
3. CD4 testing
4. Telephonic follow-up
5. Assistance with chronic disease management programmes and assistance with registration for government
6. Private ARV programmes on a monthly & quarterly basis in several locations

4.1.3 Peer-to-Peer, the recommended approach (by SWHAP)

After reading the corporate documents provided by SWHAP, it can be understood that they highly recommend a peer-to-peer approach, where Peer-Educators spread HIV related knowledge both internally and beyond the borders of the organizations.

The peer-to-peer approach is an approach where peer representatives from a specific group or population actively attempt to inform and influence the majority of the workforce. Normally, choices of Peer-Educators take into consideration leadership qualities, ability to communicate, competence, reliability, and integrity. The Peer-Educators can be viewed as ‘‘change agents’’, acting as facilitators, guides and motivators.

The peer representatives go through an extensive training provided by SWHAP, where they are educated in the health issues surrounding HIV/AIDS, STDs, sexuality and safe sex. This in order to spread the HIV related knowledge to their co-workers, family and friends. By taking action through various activities and discussions, they attempt to generate positive change in attitudes, norms, beliefs, knowledge and behavior of their co-workers.

4.1.4 Case companies, overview

Company A, Peer-to-Peer approach: Company A was chosen because of their peer-to-peer approach of transferring HIV/AIDS-related knowledge. The company has collaborated with SWHAP since 2006 and currently have eight Peer-Educators among the total number of 1096 employees. We expect company A to illustrate the most extreme example of a peer-to-peer approach where knowledge is transferred between and amongst employees with the help of their own Peer-Educators.

Company B, Top-Down approach: Company B was chosen to illustrate a clear top-down approach of transferring HIV related knowledge. The company has collaborated with SWHAP since 2004/2005 and has currently no active Peer-Educators among the 1026 employees. Instead, the management/HR department control all wellness related knowledge. The company tried the peer-to-peer approach a few years ago without success. Our expectation is therefore that company B will illustrate a strict top-down approach.

What is important to point out is that SWHAP has strongly recommended company B to create a Wellness Committee in order to handle the program internally, but company B has said no to this. Instead, a single HR manager is in charge of the program and takes a majority of the decisions by her/himself. This is a current challenge of SWHAP since they do not believe in one/a few people being too dominant in controlling the Wellness Program.

Company C, Mixed approach: Finally, the third company that we investigate was chosen because they illustrate a mix of a top-down and a peer-to-peer approach. The company has collaborated with SWHAP since 2006 and has two active Peer-Educators among the 369 employees at the head office (excluding employees on "the field"). Company C furthermore have an active HR-department in regards to Wellness related activities.

See further background to the implementation of the Wellness Programs in appendix IV.

4.2 Primary data, interviews

In the following section we will present our primary data, i.e. the findings from our interviews with the employees at the three case companies. We will start by showing a table including an overview of the responding employees in the three case companies. Secondly, we will present our findings in regards to

the company context i.e. knowledge transfer enablers at each company. This will be followed by the findings in regards to the actual knowledge transfer process, divided into sharing, storing and using of knowledge in each separate company.

The empirics will be presented foremost in the form of tables to provide an overview and ease in grasping the essence of the information. However, some topics were considered important to cover in more detail and are therefore also described in text.

4.2.1 Overview respondents

	Company A	Company B	Company C
No. of respondents	12	12	12
Average age	39	50	35
Marital Status	58% married	67% married	50% married
Education Level	58% post graduate	100% post graduate	67% post graduate

4.2.2 Company Context (Enabling factors)

In this first part of the empirical findings derived from our primary data, we will start off by presenting our findings in regards to the knowledge transfer enablers, i.e. the company specific contexts incorporating structure, culture and people.

In order to categorize the company contexts in terms of structure we have, in accordance to Rapert et al., (1998) and Walker & Ruckert (1987) investigated the level of centralization and formalization in each of the case companies. In addition, we have investigated the culture and people in each company in accordance to Davenport et al., 1998; Nonaka & Takeuchi, 1995; Demarest, 1997; O'Dell & Grayson 1998). The findings are summarized in in the four tables below.

PERCEIVED LEVEL OF CENTRALIZATION			
	Company A	Company B	Company C
Employee(s) with greatest decision power	CEO and management team	Managers and general managers	A few top managers
Number of forums where employees can raise their thoughts	Few	Few	A couple

Level of flexibility in work	Medium	High (as long as they get the job done)	High (as long as they get the job done)
Centralized vs. Decentralized Organization	Centralized	Centralized (somewhat decentralized characteristics thanks to the matrix organization)	Decentralized

Company A: The responding employees say that there is a formal chain of command where you have to go through every level of management when an issue, idea or thought is brought up by an employee.

Company B: They have a matrix organization with general managers in committees. The HR-department has an "open door policy" which showcases an open culture.

Company C: The employees explain that there is an "open door policy" at company C and most managers encourage the employees to speak up their mind. Generally, the employees state that they have a lot of freedom to decide how they want to perform their job as long as they meet certain expectations from their managers.

PERCEIVED LEVEL OF FORMALIZATION			
	Company A	Company B	Company C
Perceived level of freedom	High	High	High
Encouraged to come up with new ideas	Sometimes	Yes	Yes
Strictly monitored	Sometimes	No	No
No. of rules and policies	Strict code of conduct, few rules but many policies	Few rules but many policies	Few rules and policies
Level of formalization	High	Medium	Low

PERCEIVED CULTURE IN THE ORGANIZATION			
	Company A	Company B	Company C
Perceived level of fear in organisation	Moderate	Low	Moderate
Perceived level of collaboration	Moderate, different depending on	High	High

	hierarchy		
Perceived level hierarchical differences	High	High	Moderate
Perceived level of risk-taking	Low	High	High
Feeling towards learning	Positive	Positive	Positive
Feeling towards sharing knowledge	Positive	Positive	Positive

Company A: The respondents perceive it as easier to talk to people on the same level, in contrast to talking to managers. When talking to managers in particular, they feel as if they need to speak in "the correct manner and follow the internal processes".

Company B: The internal culture encourages risk-taking in order for the employees to develop and learn from their mistakes, an employee on a management-level explains.

Company C: Generally, the employees feel that there is a collaborative culture.

PEOPLE IN THE ORGANIZATION			
	Company A	Company B	Company C
Generally help colleagues	Often	Often	Often
Generally ask colleagues for help	Often	Often	Often
Generally learn most from	Managers, secondly co-workers	Managers, secondly co-workers	Managers, secondly co-workers
Feel safe at workplace	A majority, yes	Yes	Yes
Trust co-workers	Yes	Yes	Yes
Trust managers	Sometimes	Sometimes	Almost all
Possibility for further education within company	Yes	Yes	Moderate
Level of care	High	High	High

Company A: All responding employees see learning as an on-going process, and most state that they get a chance to learn something new every day. According to the respondents, all employees have a chance for further education within and outside of the organization.

When it comes to trust in managers, some say they are afraid of losing their jobs and would like to have a

more active dialogue with their manager. Many of the respondents mention that there have been restructurings lately, which has made them more anxious about losing their job.

Company B: Generally, the responding employees explain how the company supports individual training in several ways, both via university education and through various internal and online training. There is also a female mentorship both locally and globally at company B as well as a program focusing on trainees, an employee on a management-level explains. A few employees admit that they are afraid of losing their job from time to time since the company is cutting down on employees at the moment.

Company C: A few of the employees that we have talked to at company C have gone through further internal training.

4.2.3 The Knowledge Transfer Process

In this second part of the empirical findings derived from our primary data, we will in accordance to Demarest (1997), Nonaka & Takeuchi (1995), Wiig (1995) and Lee & Choi, (2003), present our findings concerning the knowledge transfer process through looking at the perceived behaviors and attitudes towards sharing, storing and using knowledge. We will look at each step in isolation to provide a more comprehensive picture of how the knowledge transfer is perceived to work in each of the three case companies. We have chosen to first present the knowledge transfer process separately for each case company to make it easier for the reader to distinguish the character of each case company before merging them, together with the main findings from our secondary data, in a summarizing table at the end of our empirics. This will provide an overview of how the three case companies differ or relate to each other.

In terms of sharing, we will more specifically outline the answers in terms of "mediums used for sharing, frequency and source for sharing and interest in sharing." In terms of storing knowledge, we will state answers in regards to "place and volume of storing". In terms of using knowledge, we will look into "the perceived maturity of knowledge, sensitivity and fear in regards to HIV specifically and how the employees are/are not spreading knowledge further". We will finally illustrate some of the key findings from our digital questionnaires regarding HIV in pie and pile charts.

4.2.3.1 COMPANY A

4.2.3.1.1 COMPANY A: Sharing of knowledge

PERCEIVED SHARING OF KNOWLEDGE (MEDIUMS USED)	
Mediums used for sharing wellness/HIV related information ANALOG	3 - Posters around the office and on the walls of the toilets, table talkers foremost in the cafeteria, Peer-Educators

Mediums used for sharing wellness/HIV related information DIGITAL	1 - E-mail

The responding employees explained that Peer-Educators are not as active as they used to be but that they are still considered as one medium through which they get information. A previous Peer Educator mentioned that there used to be time set aside for her to talk to her colleagues and spread knowledge but that this is no longer the case.

The responding employees further explained that the information they receive concerning the Wellness Program is shared in different ways depending on who the receiver is and what the message is. People having access to a computer mostly receive information via e-mail and people who do not mostly receive information via posters and table talkers.

PERCEIVED SHARING OF KNOWLEDGE (FREQUENCY & SOURCE)	
Frequency of shared wellness/HIV related information	Once a month
Sender of wellness/HIV related information	HR / Reality Wellness Group / Peer-educators
Who would you reach out to for more wellness/HIV related information	Colleagues & friends
General feeling towards the source of wellness/HIV related information	External information sources are perceived as trustworthy. HR is not perceived as trustworthy.

The employees felt as if they cannot trust the HR-department because they do not keep things confidential and for that reason very seldom speak to them when there is an issue of some sort.

PERCEIVED SHARING OF KNOWLEDGE (INTEREST & ATTITUDE)	
Employees generally interested in learning/receiving information	Yes on lower levels, no on higher levels in organization
Employees generally interested in sharing information	Yes
General feeling towards the way Wellness/HIV related information is distributed	Bad (wishing for more face-to-face contact)

The responding employees on higher levels in the organisation stated that they foremost make use of private alternatives when it comes to health care and that they do not know what the program can actually do for them.

When talking to the senders of information (employees part of PTG/Peer-Educators) in the organisation it became clear that most had a personal reason for participating. The main part had an HIV-infected family

member or friend. They stated that it is important to share information and that they feel obliged to share whatever knowledge they can.

The employees furthermore believed that there is room for improvement in terms of how information is spread. They would like managers to get more involved in the program as they think it could boost motivation among employees even more. The responding employees further lack communication regarding who the Peer-Educators are and what can be expected from them.

On a final note, the majority of the employees stated that they would like more face-to-face sharing of knowledge. One women who used to be a Peer-Educator expressed the following in regards to the subject of how information is currently being distributed:

"I feel that we have disappointed some. I still have people contacting me on weekends. Even without support from the company."

4.2.3.1.2 COMPANY A: Storing of knowledge

PERCEIVED STORING OF KNOWLEDGE (PLACE, VOLUME & ATTITUDE)	
Place for storing wellness/HIV related information	HR department, Wellness days, Peer-educators.
Volume of information stored	Low
Perceived attitude towards source of information	Negative

The employees perceived it as hard to get hold of information unless attending the yearly Wellness Day organized by SWHAP and RWG.

Even if the use of peer-educators is not as prominent today, some employees stated that the people who used to be "Peer-Educators" are still approached by people as they have good knowledge regarding health related issues.

The employees further emphasised that they would like health related information to be stored in additional departments. They also saw a need to distribute even more health related information and make it more easy accessible also to people who do not have a computer.

People at company A rarely seek information themselves other than on specific events, such as the Wellness Days. When the employees however do seek more wellness related information they generally turn to internal sources.

4.2.3.1.3 COMPANY A: Use of knowledge

PERCEIVED USE OF KNOWLEDGE (MATURITY OF KNOWLEDGE)	
Knowledge: HIV "know what"	Good
Knowledge: Spread of HIV	Good
Knowledge: Test of HIV	Good
Knowledge: Protection when having sex	Good
General feelings towards using a condom	Positive

Most of the employees described HIV as a "a virus that kill your immune system". The employees further stated that it is spread via sexual intercourse, blood or via sharing of needles. 90% of the respondents said that they know what a condom is. However, about 7% of the employees did not know how the HIV virus spreads.

PERCEIVED USE OF KNOWLEDGE (SENSITIVITY & FEAR)	
Perceive HIV as sensitive to talk about	No
Afraid of HIV	Yes

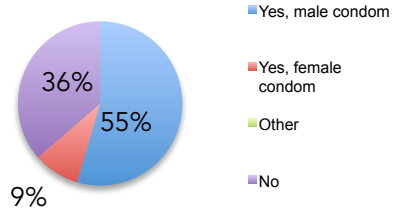
About 50% of the employees that we talked to feel that HIV is still a problem at in company A, since it affects productivity and kills people. The further brought up the fact that many employees are in denial as a big problem. The other 50% did however feel like HIV is no longer a problem since the company supports testing and monitoring of the virus, which enable for people that are sick to live with the virus.

PERCEIVED USE OF KNOWLEDGE (BEYOND THE BORDERS OF ORG.)	
Talk to people outside of Organisation	Yes, family and friends

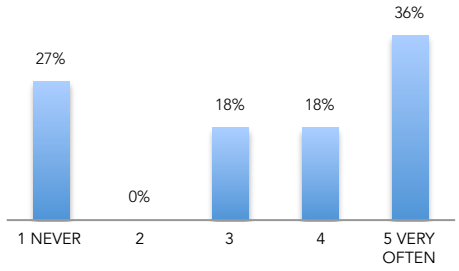
"I changed the way my church thinks. Talking about HIV was a taboo at first but I managed to get the message through to them. They are now talking about both using condoms and the dangers of getting HIV"

- Former Peer-Educator at company A

PERCEIVED USE OF KNOWLEDGE (PROTECTION DURING SEX)	
	≈36% state that they do not use protection while having sex.



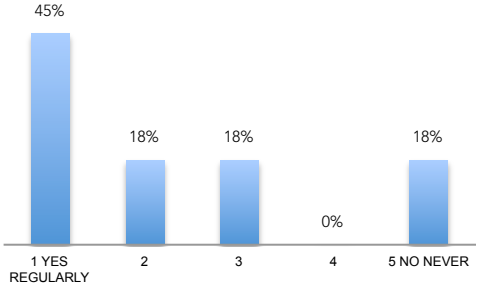
PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO USE CONDOM)



≈36% State that they tell friends/colleagues to use condom very often.

≈28% State that they never tell friends/colleagues to use a condom

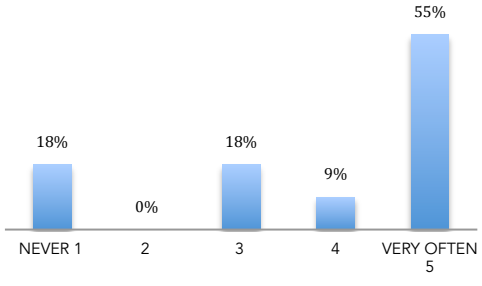
PERCEIVED USE OF KNOWLEDGE (TEST AGAINST HIV)



≈45% regularly test agains HIV

≈18% never test agains HIV

PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO TEST AGAINST HIV)



≈55% tell friends and family to test themselves agains HIV very often.

≈18% never tell friends and family to test themselves against HIV

4.2.3.2 COMPANY B

4.2.3.2.1 COMPANY B: Sharing of Knowledge

PERCEIVED SHARING OF KNOWLEDGE (MEDIUMS USED)	
Mediums used for sharing wellness/HIV related information ANALOG	4 - Posters and pamphlets in the bathroom (where the messaging is updated on a monthly basis), Through training sessions twice a year
Mediums used for sharing wellness/HIV related information DIGITAL	3 - On screensavers (with information regarding the training sessions), Via emails, Distribution of condoms in toilets

The responding employee who is responsible for the program explained that they have chosen to distribute information both offline and online since there are employees in the company who do not have access to computers. However, the focus lies on digital distribution.

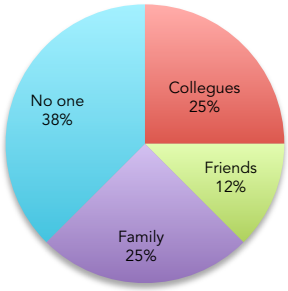
PERCEIVED SHARING OF KNOWLEDGE (FREQUENCY & SOURCE)	
Frequency of shared wellness/HIV related information	14-20 times/year
Sender of wellness/HIV related information	The Reality Wellness Group and the HR department
Who would you reach out to for more wellness/HIV related information	The Reality Wellness Group and the HR department
General feeling towards the source of wellness/HIV related information	Somewhat trustworthy

The employees stated that the frequency in which information is being shared is more than enough.

PERCEIVED SHARING OF KNOWLEDGE (INTEREST & ATTITUDE)	
Employees generally interested in learning	YES
Employees generally interested in sharing information	YES
General feeling towards the way wellness/HIV related information is distributed	Moderately positive

Concerning the attitudes of the employees on a non-managerial-level, a few expressed a longing for getting information from a Peer-Educator. This as several employees expressed a mistrust towards some managers and also the HR department. The employees explained how they think that the peer-to-peer approach would work, given a greater support from management. At the same time, they recognized the

problem of confidentiality among co-workers as they were not sure that the information shared would "stay in safe hands".

PERCEIVED SHARING OF KNOWLEDGE (WHO DO YOU USUALLY ASK FOR HIV INFO?)	
	≈38% asks no one about HIV-related infromation ≈37% ask friends and family

4.2.3.2.2 COMPANY B: Storing Knowledge

PERCEIVED STORING OF KNOWLEDGE (PLACE, VOLUME & ATTITUDE)	
Place for storing wellness/HIV related information	Reality Wellness Groups or hospital/clinics/Internet
Volume of information stored	Large (however, not yet communicated internally)
Perceived attitude towards source of information	Neutral

The responding employees stated that they generally turn to Google whenever they want more wellness related information. None of the employees said that they turn to internal sites or documents within the company and seem unaware of where such information can be found. However, the manager in charge of the Wellness Program explained that they in fact have a lot of documents and information stored that they are about to share through an extensive manual containing wellness and HIV related information.

4.2.3.2.3 COMPANY B: Using Knowledge

PERCEIVED USE OF KNOWLEDGE (MATURITY OF KNOWLEDGE)	
Knowledge: of HIV "know what"	Good
Knowledge: Spread	Good
Knowledge: Test	Good
Knowledge: Protection	Good

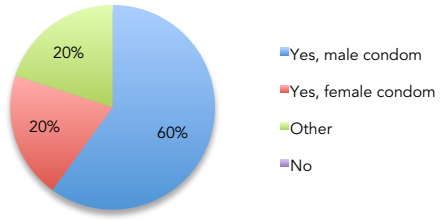
The majority of the employees referred to HIV as "Human immunodeficiency virus" and further stated that it is an illness that attacks the immune system. 75% of the employees that we talked to at Company B further explained that they know how to test themselves against HIV, but only 25% refer to testing at the company.

PERCEIVED USE OF KNOWLEDGE (SENSITIVITY & FEAR)	
Feelings towards talking about HIV	Somewhat sensitive
Feelings towards HIV as a disease	Somewhat afraid

The employees pointed out that, even though it is sometimes hard to talk about HIV, it is very important to know your status. "It is as necessary as taking your blood pressure".

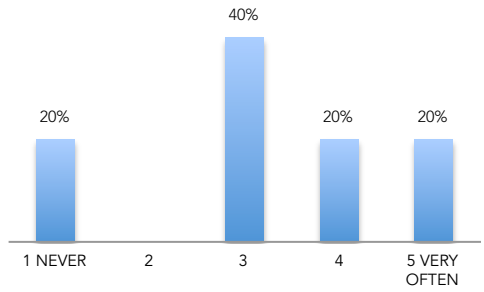
PERCEIVED USE OF KNOWLEDGE (SHARING BEYOND BORDERS OF ORG.)	
Talk to people outside of organisation	Sometimes

PERCEIVED USE OF KNOWLEDGE (PROTECTION DURING SEX)



80% state that they use protection while having sex.

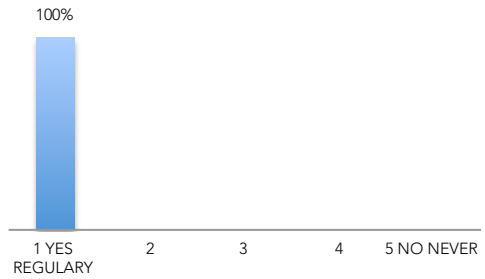
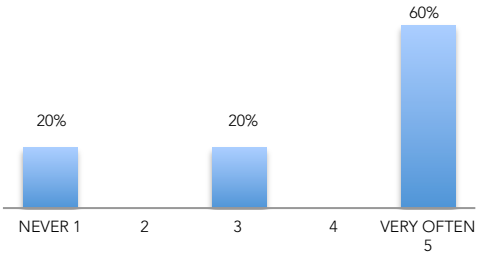
PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO USE CONDOM)



≈20% State that they tell friends/colleagues to use condom very often.

≈20% State that they never tell friends/colleagues to use a condom

PERCEIVED USE OF KNOWLEDGE (TEST AGAINST HIV)

	≈100% regularly test against HIV
PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO TEST AGAINST HIV)	
	≈60% tell friends and family to test themselves agains HIV very often. ≈20% never tell friends and family to test themselves agains HIV

4.2.3.3 COMPANY C

4.2.3.3.1 COMPANY C: Sharing of Knowledge

PERCEIVED SHARING OF KNOWLEDGE (MEDIUMS USED)	
Mediums used for sharing wellness/HIV related information ANALOG	4st - Posters and pamphlets in the bathroom where the messaging is updated on a monthly basis, Wellness day once a year, nurses, testes and counseling once a month, distribution of condoms in toilets.
Mediums used for sharing wellness/HIV related information DIGITAL	2st - E-mail, intranet

PERCEIVED SHARING OF KNOWLEDGE (FREQUENCY & SOURCE)	
Frequency of shared wellness/HIV related information	1-2 times a month
Sender of wellness/HIV related information	HR / RWG / sometimes Peer-Educators

Who would you reach out to for more wellness/HIV related information	At work from other employee. At medical centre from doctor/nurse
General feeling towards the source of wellness/HIV related information	Moderately positive

Most employees that we talked to at Company C felt that the way information is shared could be improved, especially concerning the Peer-Educators. Almost none of the Peer-Educators at company C hold wellness sessions today. They believe that Peer-Educators should get more involved, and furthermore that information about who is a peer-educator, what they do and what you can expect from one, should be communicated to all employees. "This could for example be communicated via posters and put on the boards in every department", one of the Peer-Educators suggested. Current Peer-Educators stated "It is hard when you do not get time set away to practice your duties as a Peer-Educator."

PERCEIVED SHARING OF KNOWLEDGE (INTEREST & ATTITUDE)	
Employees generally interested in learning/receiving information	Yes
Employees generally interested in sharing information	Yes
General feeling towards the way wellness/HIV related information is distributed	Somewhat negative

The employees (part of PTG) at company C, all explained how the information used to be very challenging to share, but that people are much more open towards wellness related information today. Most employees thought that this is due to the education they have received via the Wellness Program.

When talking to the peer-educators about why they feel motivated to share wellness related information a majority said that, apart from gaining a lot of personal knowledge, they are motivated to help other people.

"I love people and I love to see people smile"

- Peer-Educator explains

The employees further explained how there, two years ago, was an extremely popular guy among the employees who suddenly got sick in HIV and eventually died from AIDS. "When he got sick, it touched everyone, it was a wake-up call for all of us."

Further, when talking to managers, it seemed as if their interest in sharing and receiving wellness related information was lower. They stated that they foremost rely on private hospitals/clinics and generally does not have to utilize the Wellness Program related services.

4.2.3.3.2 COMPANY C: Storing Knowledge

PERCEIVED STORING OF KNOWLEDGE (PLACE, VOLUME & ATTITUDE)	
Place for storing wellness/HIV related information	E-mail, HR
Volume of stored information	Moderate
Perceived attitude towards source of information	Somewhat negative

Generally, the employees at company C feel that there is enough information stored about wellness internally but they perceive the place where it is stored as negative. One employee pointed out that it is hard for employees without a computer to find further information as most information is spread via e-mail.

4.2.3.3.3 COMPANY C: Using Knowledge

PERCEIVED USE OF KNOWLEDGE (MATURITY OF KNOWLEDGE)	
Knowledge: of HIV "know what"	Good
Knowledge: Spread	Good
Knowledge: Test	Moderate
Knowledge: Protection	Somewhat good

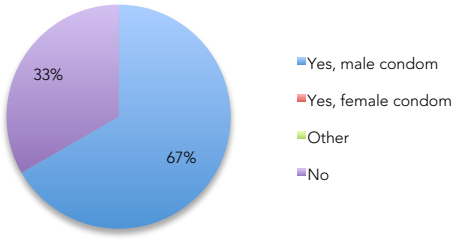
The employees referred to HIV as a virus that affect the immune system and that it, if not managed, can become full-blown AIDS. 70% of the employees know how to protect themselves from getting HIV. However the employees part of PTG stated that sometimes people seem to think that taking an HIV-test in itself is a protection and that people do not seem to understand that it is important to test several times and not just once.

PERCEIVED USE OF KNOWLEDGE (SENSITIVITY & FEAR)	
Perceive HIV as sensitive to talk about	No
Afraid of HIV	Somewhat afraid

Generally, the employees stated that younger people are more open-minded. A few of the respondents felt like HIV is still a problem in the organization (if it is left unnoticed) since it affects the level of productivity of the employees. Further, the employees are not that afraid of the virus and as they see it as a manageable disease. A few admitted that it can be challenging to use a condom, especially when in "long-term" relationships. Several employees brought up the fact that they have lost two colleagues to AIDS in recent years, which they believe have made people think twice before having unprotected sex.

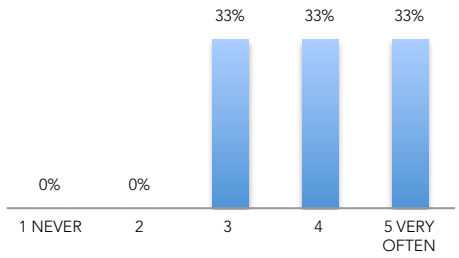
PERCEIVED USE OF KNOWLEDGE (SHARING BEYOND BORDERS OF ORG.)	
Talk to people outside of Organisation	Yes, family and friends

PERCEIVED USE OF KNOWLEDGE (PROTECTION DURING SEX)



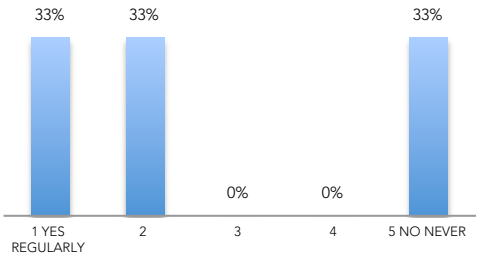
≈33% state that they do not use protection while having sex.

PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO USE CONDOM)



≈33% State that they tell friends/colleagues to use condom very often.

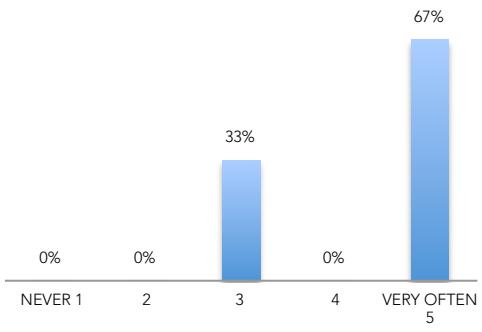
PERCEIVED USE OF KNOWLEDGE (TEST AGAINST HIV)



≈33% regularly test against HIV

≈33% never test against HIV

PERCEIVED USE OF KNOWLEDGE (TELL FRIENDS/COLLEAGUES TO TEST AGAINST HIV)



≈67% tell friends and family to test themselves agains HIV very often.

For more primary data regarding company A, B and C. See Appendix V, with additional charts.

4.3 Secondary Data, Perceived Performance

After taking part of the statistics provided by SWHAP we have chosen to include the most relevant KPIs for the purpose of our study below.

PERCEIVED PERFORMANCE (SECONDARY DATA)			
	Company A	Company B	Company C
Employees trained in 2015	348	734	260
Number of Peer- Educators	8	0	2
Completed HCT (% of total workforce in 2015)	38,3%	71,5%	34,7%
Condoms distributed (in 2015)	2500	3000	6000
No. of employees Peer-Educators have talked to (internally)	96	-	120
No. of people Peer-Educators have talked to (externally)	12	-	50
Employees per Peer-Educator	137	-	375
% of employees trained in 2015	32%	71%	60%

4.4 Summary of Main Empirical Findings

	Company A	Company B	Company C
STATED AND ACTUAL APPROACH			
Stated approach (2nd data)	Peer-to-peer	Top-down	Mix of Top-down & Peer-to-peer
PERCEIVED COMPANY CONTEXT AS AN ENABLING FACTOR			
Corporate structure (1st data)	Centralized	Centralized (somewhat decentralized characteristics)	Decentralized
Level of formalization (1st data)	High	Medium	Low
Corporate culture (1st data)	Moderate level of collaboration and low risk-taking	High level of collaboration and medium level of risk-taking	Moderate level of collaboration and high level of risk-taking
PERCEIVED INTERMEDIATE OUTCOME IN TERMS OF SHARING			
No. of mediums used for sharing ANALOG / DIGITAL (1st data)	3/1	4/3	4/2
Primary sender of wellness/HIV related information (1st data)	HR/RWG/Sometimes Peer-Educators	RWG/HR	HR/RWG/Sometimes P-E
Who would you reach out to for more Wellness/HIV related information (1st data)	Friends and colleagues	RWG / HR	Colleagues and doctor
General feeling towards the source of wellness/HIV related information (1st data)	External sources are perceived as trustworthy, HR not.	Somewhat trustworthy	Moderately positive
Employees generally interested in sharing/receiving information (1st data)	Yes	Yes	Yes
General feelings towards sharing of wellness/HIV info (1st data)	Bad (would like more face-to-face contact)	Moderately positive	Somewhat negative
PERCEIVED INTERMEDIATE OUTCOME IN TERMS OF STORING			
Place for storing wellness/HIV related information (1st data)	HR department, Wellness days, P-E	Reality Wellness Groups or hospital/clinics	E-mail, HR
Perceived attitude towards source of information (1st data)	Negative	Neutral	Somewhat negative
PERCEIVED INTERMEDIATE OUTCOME IN TERMS OF USING			
Knowledge: of HIV "know what" (1st data)	Good	Good	Quite good
Knowledge: Spread (1st data)	Good	Good	Good
Knowledge: Test (1st data)	Good	Good	Moderate
Knowledge: Protection (1st data)	Good	Good	Good
PERCEIVED PERFORMANCE OF THE KNOWLEDGE TRANSFER PROCESS			
Employees trained in 2015 (2nd data)	348	734	260
Number of Peer educators (2nd data)	8	0	2
Completed HCT in 2015 % of total (2nd data)	38,3	71,5	34,7
Condoms distributed in 2015 (2nd data)	2500	3000	6000

5.0 Analysis

In the fifth chapter, the empirical data presented in chapter four will be analyzed using the theoretical and conceptual framework of our study with the underlying goal of answering the posed problem formulations. The first section is set out to analyze the knowledge transfer enablers referred to as the context specifics of each case company (i.e. structure, culture and people). The second section analyses the actual process for sharing, storing and using knowledge in each case company and furthermore discusses how the contextual variable affects each of these steps in terms of both intermediate outcome (perceived attitudes and behavior) and performance (statistics provided by SWHAP).

5.1 Knowledge Transfer Enablers, Organizational Context

5.1.1 Structure - Level of centralization and formalization

After analyzing our empirical findings it became evident that company A is driven primarily by the management team with few forums where the employees can express their thoughts and furthermore has a formal chain of command. The company can therefore be said to illustrate the most centralized company structure (Walker & Ruckert, 1987).

Company C on the other hand, has more of a decentralized organizational structure where the employees are encouraged to speak up their mind and thoughts within various internal forums (Walker & Ruckert 1987).

The structure of company B is more difficult to analyze since the organization on the one hand has a centralized structure since the power lies on a few top-managers in the organization. On the other hand, the matrix organization and open door policy within HR gives the employees a feeling of having a lot of power to decide individually, which constitutes a more decentralized structure (Walker & Ruckert, 1987).

After further analyzing our empirics in relation to theory it can be understood that in an organization where there is a strict formal chain of command with many formal procedures and policies to follow, the level of formalization is expected to also be relatively high. This was the case in Company A, whilst Company B showcased a moderate level of formalization (Rapert & Wren 1998). In company C however, there is little use of rules and policies and few over-arching policies to follow. Which furthermore indicates a lower level of formalization (Rapert & Wren 1998).

5.1.2 Culture and People

Generally, the perceived value of learning seems to be high within all three case companies. The companies further seem to actively try to encourage a learning culture by offering various courses, educational programs and mentorships for their employees. According to Damanpour (1991) this is a key

enabling variable for knowledge transfer processes to succeed. In particularly company A and B seem to be supporting various individual learning alternatives, while our understanding is that there is room for more individual learning at company C.

Further, in order to analyze the culture of a company it is vital to look at the relationship between people within the organization (Davenport et al., 1998). When studying the relationship between people on the same level of "hierarchy" in the three case companies, it can be interpreted that the culture is *caring*. We did find a quite high level of mutual trust among employees on the same level, the employees ask each other for help and they like sharing knowledge with their co-workers which according to Ichijo, K. et al. (1998) is significant to a caring environment that stimulates learning and development.

However, in company A and B we could identify a problem in terms of trust towards managers and in particular the HR-department. The employees seem reluctant to talk to, share thoughts and trust their managers which signals a more distant quality of relationship between employees on different levels in the organization and a lower level of care in these particular organizational relationships.

As most researchers have shown culture to be the principal determinant of success in KM (Davenport et al., 1998), it can be concluded that the culture of company C has great potential to generate a learning environment, where both a top-down, and particularly a peer-to-peer approach is likely to work. However company A and B needs to improve their level of trust between various hierarchies in order to improve the prerequisites needed to foster a learning environment. As Hedlund G (1994) states, people who do not trust each other will be less likely to collaborate which will harm the knowledge transfer process.

5.2 Actual knowledge Management Processes

5.2.1 Actual KM Process in Company A

Our initial expectation after reading the corporate documents regarding company A, was that the company was using a peer-to-peer approach with eight active Peer-Educators. However, when analyzing our primary data findings, we can see that this is true to some extent, but due to lack of internal support from management many of the Peer-Educators are today, in fact, inactive.

Given that the responding employees explained that the Peer-Educators used to be more active a few years back, it seems like company A used to apply more of a process view. As most of the current Peer-Educators are inactive, the program seems to have lost direction and speed, making the Wellness days the most central part of the program. Further, it seems like none of the element and/or process-views of knowledge transfer are properly applied, since there is no clear focus on either a peer-to-peer or top-down approach of transferring knowledge.

5.2.2 Actual KM Process in Company B

In the corporate documents it was stated that company B use a clear top-down approach to transferring HIV related knowledge, which implies that they have applied an element view of knowledge transfer. According to our primary data, this turned out to be true since they currently do not use any Peer-Educators and instead transfer information via a top-down approach, which according to theory signifies the application of an element view of knowledge (Preuss & Cordoba-Pachoni, 2009).

5.2.3 Actual KM Process in Company C

We started analyzing company C, with expectations from reading the corporate documents, to find a mix of a top-down and peer-to-peer approach of transferring knowledge. Consequently, we were also expecting to find a mix of an applied element and process view of knowledge. However, after analyzing the empirics, it became evident that none of the approaches were especially present within the organization. As in the case of company A, what once was a well-functioning peer-to-peer approach with an applied process view of knowledge, is no longer enforced and supported from a management perspective, which makes it lose speed and direction.

Even though there are two active Peer-Educators within the organization, judging by our empirics, these does not feel supported enough to be activate within the Wellness Program. The implementation of a top-down approach can further be questioned because of the perceived lack of engagement from the management team.

In summary, it is true that company C tries to apply both an element and a process view of KM. However, it is evident that the process view is more apparent and that none of the two approaches are encouraged enough for the Wellness Program to reach its full potential. With this in mind, the analysis will primarily treat the knowledge transfer process in company C from a process view of knowledge.

5.2.4 Overview of stated and actual KM approaches

The table below summarizes the findings in regards to the stated approach in the corporate documents provided by SWHAP, the actual approach that we came to find after analyzing the empirical data and consequently the reflected view of knowledge transfer supported by theory. These findings will be further elaborated on below where the three main components of the knowledge transfer process, i.e. sharing, storing and using of knowledge (Lee & Choi, 2003), will be analyzed one by one in isolation to provide a more comprehensive picture of how the knowledge transfer is perceived to work in each of the three case companies.

OVERVIEW STATED & ACTUAL APPROACH + REFLECTED VIEW OF KNOWLEDGE			
	Company A	Company B	Company C
Stated approach	Peer-to-peer	Top-down	Mix of Top-down & Peer-to-peer
Actual approach	Faulty peer-to-peer	Top-down	Faulty mix of Top-down & Peer-to-peer
Reflected view	Process view	Element view	Mix, with an emphasis on the process view

5.3 Intermediate Outcome and performance of KM processes

5.3.1 Sharing of Knowledge

In order to describe the process of sharing knowledge within the three case companies in an exhaustive and comprehensive way we have, grounded in theory, chosen to discuss the following variables in the section below; (1) Mediums used for sharing knowledge (2) Level of syntactic and semantic information spread. (3) Sender and receiver roles within the organization.

5.3.1.1 Mediums used for sharing knowledge

All three case companies use a variety of offline and online mediums to share knowledge. In accordance to Ichijo et al (1998) this is good since it enables for a learning environment to develop. However, the number of personal sources used when sharing information varies between the companies. Company A and C use Peer-Educators and company B primarily use the HR-department and external sources such as the RWG when sharing wellness related information.

Looking at the actual performance statistics of how many employees the Peer-Educators have talked to, it becomes evident that the Peer-Educators in company C are much more active than in company A. Even though there are only two Peer-Educators in company C, they state that they have talked to 120 employees during 2015. In company A on the other hand, the eight peer educators state that they have talked to 96 employees during 2015.

In all three case companies, the employees further expressed a general longing for more face-to-face contact when receiving wellness related information. This signifies a desire to apply more of a process view of knowledge within all companies as theory tells us that this view in fact highlights the importance of organizational members to engage in small group exchanges of knowledge and stress the positive impact that can come from socialization in work groups (Pedersen, 2006; Roloff, 2008).

At company A and C with active Peer-Educators, the responding employees also expressed a need for more communication regarding who the Peer-Educators are and what can be expected from them. By

analyzing our primary data, we believe that this is another indication of lack in management support in both companies, since no one currently takes on the role of informing and setting expectations in regards to the Peer-Educators.

As Hope (2010) states, the peer-to-peer programs and process view should not be regarded as the only solution for positive results with respect to HIV/AIDS interventions. Hope (2010) states how programs may fall victim to factors like improperly trained Peer-Educators and intergroup relations characterized by feelings of jealousy and competitiveness if they are not managed in a proper way. Despite previous perceived success of the peer-to-peer approaches, this could be one explanation to why the programs seem to be failing in both company A and C.

Referring back to the lack of management support in company A and C while also taking the two company contexts into account, it is possible that company A, with a more centralized organizational structure is suffering more from the lack of management support than the employees in company B and C with a more decentralized organizational structure. This furthermore indicates that company A would benefit from applying more of an element view of knowledge, as it can be problematic to maintain a peer-to-peer approach with a reflected process view of knowledge in a context where employees are used to receiving a majority of information and instructions from managers on a top-level (Preuss & Cordoba-Pachoni, 2009).

In company B on the other hand, there is a lot of management support behind the Wellness Program and a clear processes for sharing information. One likely explanation could be that the applied element view matches the organizational context and therefore reaches better results.

However, several employees in company B point out the problem of having all wellness related information stored within the HR-department. A likely explanation to this is the current trust issue between employees and the HR-department. This in turn could be traced to the fact that the company is currently in a downsizing period, naturally increasing the level of internal fear and distrust in HR. This is problematic as trust, by definition is the reciprocal faith in others intention and behaviours and furthermore is vital in order for learning between individuals in an organization to occur (Kreitner & Kinicki, 1992).

With support from Lee and (2003) it can be concluded that company B has a well-developed technical system for sharing HIV related knowledge. This as they have well functioning processes for sharing knowledge and also a clear division of tasks in regards to who is responsible for sharing. Company A and C on the other hand, seem to have a less developed technical system, but a more developed social system that rely on people i.e. Peer-Educators to share information.

5.3.1.2 Syntactic and semantic aspects of information

When looking at the internal sharing of wellness related knowledge in the three case companies, it is clear that the level of syntactic and semantic aspects of information vary. In company B, the focus lies on high frequency and volume of information and it is seldom connected to personal stories or experiences.

According to Shannon and Weaver (1949) this kind of information have high levels of syntactic aspects. This is furthermore in line with theory in regards to company B's element view of knowledge, where it is common to share information through documents and policies (Liebeskind, 1996), consequently making it hard to attain deeper meaning to the message (Shannon & Weaver, 1979).

Company A and C on the other hand, showcase a greater level of semantic aspects of information as they through the use of Peer-Educators are better equipped to add meaning to the information via storytelling and the use of real life cases. From this it can, once again, be concluded that company A and C applies a process view of knowledge to a greater extent since the Peer-Educators play a major role in sharing information (Preuss & Cordoba-Pachoni, 2009).

In terms of creating new knowledge, Shannon & Weavers (1949) previous research tells us that the semantic aspects of information are more relevant as it focuses on conveying meaning to the message. This was furthermore supported in our empirical findings, as the employees generally state that "personal experiences" is the main reason for sharing and receiving HIV related knowledge. It is thus plausible to believe that incorporating more face-to-face sharing of information likely would increase efficiency in the knowledge transfer processes of all companies.

> "When he got sick, it touched everyone, it was a wake-up call for all of us."
>
> -Employee at company C

Personal stories and experiences of HIV is furthermore the primary reason to why a majority of the active Peer-Educators has chosen to participate in the program.

However, in company B, with no Peer-Educators and consequently little occurrence of semantic aspects of information, the perceived intermediate outcome and performance of the Wellness Program, still show good results which in fact contradicts theory. One possible explanation to the success of the Wellness Program in company B could, as stated above, be the good fit between the company context and the applied element view of KM. Theory clearly states that a fit between the KM-project and context is a necessary prerequisite in a successful knowledge transfer (Davenport et al., 1998). It is however also possible that there exist semantic aspects of information in company B through an active interaction among employees. Something, which we did not have the possibility to look at or measure within the scope of this study.

5.3.1.3 The knowledge participants, Sender & Receiver

As Davenport & Prusak (1998) states, in order for a knowledge transfer to occur, both the sender and the receiver of knowledge need to be active in their specific roles. Also the level of competence of the sender and the relationship between the two affect how the receiver values the transferred knowledge (Lin et al., 2005).

We have seen this play out very differently in the three case companies. In company A and C, where the support for Peer-Educators seem to have decreased, more responsibility for the transfer of knowledge has

been put on the management team instead. It was however revealed that also the management commitment to the overall Wellness Program seem to have decreased lately, resulting in no one taking on the role as a sender of knowledge which seem to inevitably have made also the receivers of knowledge inactive. In summary, this makes the relationship between senders and receivers of knowledge non-existent in company A and C, which according to theory will effect the transfer of knowledge negatively (Davenport & Prusak 1998).

On the contrary, in company B, the management and HR-department takes on an active role as sender of knowledge. However, there is not enough emphasis on the employees as receivers resulting in a less active participation from them (Davenport & Prusak, 1998). This is also reflected in the results from the primary data, showing how a majority of the responding employees in company B (38%) are passive and does not ask anyone for HIV related information.

One possible reason for the different levels of activation in the roles of senders and receivers of knowledge could be the different applications of element and/or process views in the companies. With a top-down approach reflecting an element view of transferring knowledge, it is plausible to believe that the employees are used to being inactive in the knowledge transfer compared to employees in a peer-to-peer approach, where the process view is applicable. In addition, it would entail that the management in a top-down approach would have a higher level of motivation (Easterby-Smith et al., 2008) and therefore are more active in sharing information compared to managers in a peer-to-peer approach. The high activation of senders, i.e. HR manager in a top-down approach is furthermore confirmed by analysing the primary data from company B.

In all three case companies, it could furthermore be detected that the managers signalled that the HIV-related information was of rather low importance to them personally, since a majority of them turn to private doctors/clinics for their personal health. With reference to theory, this is problematic since it will influence the managers' perceived benefits in engaging in the transfer (Vining, 2003). The managers in this case could be less prone to disseminate it to their co-workers on lower levels, for whom the information, in contrast, is highly relevant. In theoretical terms, this in turn, indicate a low sender's motivation among the managers (Easterby-Smith et al., 2008) which we further could see indications of in all three companies.

Furthermore, as the employees on lower levels within the three case companies, should not only be viewed as receivers but also senders of knowledge, it was interesting to find that the majority generally liked sharing information and thought that it was important. According to theory, this indicate that employees in non managerial positions are better at estimating the value of HIV/AIDS related knowledge than managers (Easterby-Smith et al., 2008) which further is an additional argument to why a peer-to-peer approach likely is to prefer when transferring this type of knowledge.

The theory further describe the importance of absorptive capacity, referring to the receiver's ability to value, assimilate and apply new knowledge (Cohen & Levinthal, 1990). Cohen and Levinthal (1990) suggest that the absorptive capacity to a great extent depends on the degree of prior related knowledge, which indicates that HIV related knowledge is likely to transfer more easily in an organization that has a history of HIV positive cases, than an organization that has never come in contact with the disease before.

A lack of pre-existing knowledge can sometimes be the reason to why the willingness to engaging in a transfer is not enough for the knowledge transfer to take place (Cohen & Levinthal, 1990; Szulanski, 1996). Which further supports our previous argument, that the organizations should strive towards sharing more real-life-cases concerning HIV and instead of trying to hide the numbers of sick cases in order to increase the absorptive capacity among the receivers.

5.3.2 Storing of Knowledge

In order to describe the process of storing knowledge within the three case companies in a comprehensive and exhaustive way we have, with support from theory, chosen to discuss the following variables in the section below; (1) Volume of information stored. (2) Where the information is stored. (3) How the information is stored.

5.3.2.1 Volume of information stored

In line with our expectations, due to use of different KM approaches and consequently reflecting views, the companies have varying volumes of information stored. Company B showcased the largest volume of information stored, also in electronic resources, which is in line with what theory claims is normal regarding an element view of knowledge. In addition, company A and C had less information stored, which also matches theory typical for a process view of knowledge (Preuss, L. & Cordoba-Pachoni, 2009).

Generally, the employees at company C seem to be pleased with the volume of information stored while the employees in company B are neutral, and the employees in company A see a need for more stored wellness information. In the next section we will further analyse the employees' perception of the ease of getting in contact with the information more in depth.

5.3.2.2 Internal and External storing of information

It is furthermore interesting to look at *where* the employees turn to find more HIV related information. By analysing our primary data, it can be understood that the employees within company A and C generally turn to internal sources to find more HIV related information, which is in line with what theory tells us is common in a process view, where the organization becomes the medium in which individuals continuously articulate and assimilate knowledge in interactions with others (Nonaka and Takeuchi, 1995; Wenger et al., 2002)

In contrast, the employees in company B turn to external sources, i.e. the Reality Wellness Group or hospital/clinics to find more HIV related information. This somewhat contradicts theory, since the theory states that it is important to keep the knowledge internally as it is seen as a strategic asset in the element view. Usually, implying that organizations close their boundaries to external influence for the benefit of maintaining a particular niche or source of competitive advantage (Liebeskind, 1996). In the case of

company B, they have opened up for the RWG to both share and store information that means that knowledge is no longer the company's strategic asset.

5.3.2.3 Social/Technical storing of information

In company A and C, the information is primarily stored in social assets, i.e.. peer-educators. What became evident during the interviews in company A and C was however the low level of internal support for the peer-educators from the organisation. A few Peer-Educators explained how they had been recognized for their work while others expressed a longing for more internal support in order to both share and store the wellness related information properly.

The Peer-Educators further expressed a will to share experiences and insights amongst them, helping each other improve as peer-educators. This importance of group exchanges is highlighted in the process view of KM where it is regarded as highly important to enable organizational members to engage in socialization in work groups inside the firm (Pedersen, 2006; Roloff, 2008). Ideally, a process oriented view on KM can lead organizations to create structures of dialogue with the aim of enabling the exchange of ideas or joint solutions to problems by people working across areas as well as beyond the formal boundaries of the organization (Pedersen, 2006; Roloff, 2008).

In summary, based on both findings from the interviews and theory it seems like the companies with Peer-Educators would benefit from creating an internal community where the Peer-Educators can socialize and improve their work together, both internally and in society as whole which is furthermore the goal of SWHAP.

In company B on the other hand, a majority of the information is stored in technical assets, such as on the internet and in corporate documents. Which is furthermore in line with theory describing an element view (Preuss & Cordoba-Pachoni, 2009).

5.3.3 Using of Knowledge

As theory states, action is closely related to “what we know” (Gruber 1989). We will therefore analyse the Use of knowledge within the three case companies in a comprehensive and exhaustive way in this section. This by discussing the following parameters (1) Level of explicitness/tacitness in knowledge. (2) Level of active participation in the Wellness Program. (3) Volume of information spread across the borders of the companies.

5.3.3.1 Explicit vs. tacit knowledge

Judging by our primary data, the majority of the responding employees generally have good knowledge in regards to HIV, how it is spread, how to test and how to protect oneself from the virus. Our perception is therefore, with support from Hansen et al., (1989), that the explicit knowledge has been transferred successfully within all three case companies.

Furthermore, we analysed the perceived use of knowledge in terms of taking an HIV test and using protection during sex in our primary data. Generally, company A and C showcase lower numbers in both categories compared to company B which signals that it is possible that the explicit knowledge has not lead to tacit knowledge or actual "know how" in the minds of the employees at company A and C.

By also analysing the actual performance in terms of completed HCT tests for 2015, the numbers go in line with our findings in the primary empirical data.

Company B has the highest numbers of completed tests (71,5%) followed by company A (38,3%) and lastly company C (34,7%), which again signals that knowledge is likely to be most mature and closer to tacit "know how" in company B compared to company A and C.

However, also incorporating the number of distributed condoms during 2015, from our secondary data in terms of actual perceived performance, we find a discrepancy to what was just stated. Company C is actually the company where most, 6000 condoms have been distributed, whereas company B have distributed 3000 condoms and company A have distributed 2500 condoms. This indicates that the number of distributed condoms does not necessarily reflect the perceived number of condoms used.

Drawing back to the previous discussion of syntactic and semantic aspects of information in the organisation, one possible explanation to why we found indications of low tacit information in Company A and C could lie in an insufficient occurrence of the syntactic aspects of information (Shannon and Weaver, 1949). This line of reasoning is supported by Liebowitz & Beckman (1998), who states that when information is not personalised, it is hard to give greater meaning to it, consequently making it stay at the level of "know what" i.e. explicit knowledge, and therefore never reaches the maturity of "know how" i.e. implicit knowledge. Furthermore, Liebowitz & Beckman (1998), supported by Smith (2001) claim that nearly two thirds of the work-related information that is gradually transformed into tacit knowledge comes from face-to-face contact. We would like to argue that this is a way of personalizing the message, and further, an additional argument to why the Peer-Educators should get more internal support in order to become more active.

In the case of company B, the theory is however contradicting. Company B seem to in fact be the company with the most successful transfer of explicit knowledge to tacit knowledge, given the positive figures of HIV-testing and protection during sex, despite not using any face-to-face communication. The explanation to this could be found in the previous discussion of the deeply rooted top-down-context which legitimises the source of information in a way that could make the employees more attentive to these messages, regardless of whether the knowledge extracted from them can be categorized as tacit or not, than employees at company A and C (Lin et al., 2005).

What is furthermore interesting to analyse is how the employees feel towards talking about HIV. The responding employees in company A and C are generally more open towards talking about HIV compared to the responding employees in company B. Connected to our previous discussion regarding the importance of having an active sender and receiver of information, this could be an effect of the very passive role of the receivers in company B (Davenport & Prusak, 1998).

Furthermore, it is interesting to notice that even though the employees in all three companies admit that they talk more openly about HIV today than they did a few years ago, it does not mean that they are less afraid of the disease.

Having analysed the level of explicit and tacit knowledge in the organisation, we would like to point out that it is important to remember that our case study comprise a small number of respondents, and as theory states, many factors, both controllable and uncontrollable, affect the pursuit of tacit and explicit knowledge (Smith, 2001). For example, many of the respondents are in longstanding relationships, which could mean that they do not use condoms or take HIV tests since they do not see a need for it. Further, as theory states, it is nearly impossible to know where and when tacit knowledge emerges or how knowledge has been applied in real life. Our analysis of the occurrence of tacit versus explicit knowledge in the three case companies should therefore be seen as a rather philosophical analysis highlighting important indications of different kind of knowledge creations.

5.3.3.2 Spreading knowledge beyond the borders of the firm

Based on our initial expectations on the used KM approaches, theory would imply that company A and C due to their peer-to-peer approach and reflecting process view on knowledge has the greatest potential to spread knowledge both internally and beyond the formal boundaries of the firm (Preuss & Cordoba-Pachoni, 2009). When analysing our primary data we can confirm that the expectations were in line with theory. The two companies did showcase better results both in terms of telling friends and colleagues to take an HIV test and also in encouraging friends and colleagues to use condoms.

At company A it was particularly evident that the applied process oriented view on knowledge might have succeeded in encouraging what theory refers to as "a self-reflection on societal topics" as one of the employees stated:

"I changed the way my church thinks. Talking about HIV was a taboo at first but I managed to get the message through to them. They are now talking about both using condoms and the dangers of getting HIV."

Furthermore, theory states that managers in organisations that succeed in rethinking their role in society would also have a greater emphasis on long-term goals, with a natural exploration of the satisfaction of needs and aspirations of employees and society in general (Preuss & Cordoba-Pachoni, 2009). This could however not be traced back to company A as several employees explained to us that there is a lack of management support for Peer-Educators and the Wellness Program overall in the organisation.

Consequently, no evidence of this being thanks to the actual management of the program was found.

Company B showcase lower numbers in terms of telling their friends and family to test themselves and to use protection while having sex. This could be explained by the top-down approach and reflected element view of knowledge where the receiver's role is generally less active in spreading knowledge both internally and externally (Lin et al., 2005).

6.0 Concluding Discussion

With basis in the empirical findings extracted from corporate documents, interviews and performance data we analyzed the gathered material with support from theory. In the following section we will summarize the key findings of our analysis to in the next section present the answers to our previously stated problem formulations.

This thesis was set out to increase the understanding of how the HIV related knowledge is shared, stored and used within and beyond the borders of the three case companies in Johannesburg, South Africa. In addition, the thesis aimed to understand how the company specific contexts affect the perceived intermediate outcome and performance of the knowledge transfer approaches and reflecting views. The final aim of this thesis was to increase the understanding of how the knowledge transfer, given the specific company contexts, can be *improved*.

Company A states that they currently use a peer-to-peer approach, reflecting a process view of knowledge (Preuss & Cordoba-Pachoni, 2009). After analysing the findings from our empirical study, we believe that this can be questioned since only a few of the eight Peer-Educators seem to be active in the organization. This implies that the sender and receiver relationship is not as active as it should be, further resulting in the expressed lack of face-to-face contact by the employees (Lin et al., 2005). One possible reason for this is the decreased management support that the Wellness Program has experienced lately. Given this fact we have concluded that the peer-to-peer approach seem to be failing at the moment and consequently that the process view is not applied to a full extent in company A.

With a centralized and formalized structure, as displayed in company A, theory states that an element view and consequently a top-down approach is likely to be the most successful way of handling KM since the employees in such a context are used to taking directives from the management team which is likely to drive the desired behaviour to a greater extent (Liebeskind, 1996). Nevertheless, based on the mindset of the employees of company A, the culture seem to foster a learning environment, which we believe indicates that a peer-to-peer approach is likely to work very well as well. This given a support of the social system through a more advanced technical system where management support is increased and the process control is improved (Lee & Choi, 2003).

We have identified a similar situation with inactive Peer-Educators and lack of management support also in company C, who initially stated that they apply a mix of both the Top-Down and Peer-to-Peer approach, consequently also a mix of both the element and process view. After analysing our primary data it turns out that only one of the two Peer-Educators are active which indicates that the company is likely to have a similar lack of face-to-face contact as was identified in company A. However, in terms of context, company C differ from company A as they have the least formalized and centralized structure. This indicates that the current peer-to-peer approach i.e. process view theoretically should work better in company C compared to company A (Preuss & Cordoba-Pachoni, 2009). This was supported both in accordance to our primary and secondary data. We could measure a higher level of semantic aspects of knowledge and furthermore in terms of perceived performance it was found that more employees have gone through training and that the Peer-Educator have talked to more people inside and outside of the

organization than what was measured in company A (Liebeskind, 1996).

It can be extracted from our empirics that the current view and approach practiced in both company A and C has not evolved from an active decision making from management. I.e. the inactivation of the peer-to-peer approach has happened over time, without a clear direction or new focus on spreading knowledge from for example a Top-Down approach. The Wellness Program has as a result been neglected to a point where today, no one, neither a Peer-Educator nor a manager feel responsible for the program and further spread of wellness related knowledge information.

Analyzing the findings from our interviews further, and furthermore with support from theory, it can be concluded that the employees and current Peer-Educators likely would benefit from having a community for Peer-Educators and further need more internal communication regarding who the Peer-Educators are and what can be expected from them in order for the peer-to-peer approach to work (Pedersen, 2006 & Roloff, 2008).

Judging by this fact, it can be concluded that company C, like company A, probably would benefit from building a more stable social system, and in addition develop their technical system for the benefit of a greater control and support of internal processes (Lee & Choi, 2003). However, in contrary from company A, it is not about implementing a top-down approach where the management is in charge of the knowledge transfer, but for the management to facilitate, through internal communication and creation of a Peer Community, a better foundation for the peer-to-peer program to work on.

Company B on the other hand is the only company that proclaimed to be using a top-down approach in the corporate documents. Judging by the company context, with moderate formalization and a structure with both centralized and decentralized characteristics, the chosen top-down approach is according to theory likely to work quite well (Liebeskind, 1996). When we further analyzed the perceived performances, it became clear that the chosen approach was driving the desired behaviours resulting in the best perceived results compared to both company A and B in terms of both percentage of employees in 2015 that has been; trained and completed HCT.

However, despite the fact that the top-down approach created a good knowledge transfer from the sender to the receiver in company B, it did not stimulate a two-way communication. Furthermore, the current set-up puts the Wellness Program solely in the hands of the HR-department, more specifically in one person's control, which is not optimal in a case where an unforeseen problem, i.e. downsizing would arise. For that reason, we would like to argue, with support from Lee & Choi (2003) that company B would benefit from a more developed social system as it would enable them to take into account the attributes of people and relationships in the organisation when drawing up a strategy for sharing information. In practice, this could mean an implementation of Peer-Educators would help them to avoid stagnation of the knowledge transfer process in times of turbulence. It could furthermore help them withhold active knowledge transfer participants and potentially increase the level of tacit knowledge, which could potentially improve the dissemination of knowledge more efficient (Preuss & Cordoba-Pachoni, 2009).

6.1 Overview of concluding discussion

As Davenport et al (1998) states, it is central that the KM projects fits with the existing company culture and context in order to become successful. We have therefore summarized our findings of how the KM approaches and -views play out also taking into account the company specific context. We furthermore include possible improvements, given company specific contexts, in all three case companies.

	Company A	Company B	Company C
Stated KM approach	Peer-to-peer	Top-down	Mix of Top-down & Peer-to-peer
Actual KM approach	Faulty peer-to-peer	Top-down	Faulty mix of Top-down & Peer-to-peer
Reflected KM view	Process view	Element view	Mix of process and element view
Company structure	Centralized	Centralized (+decentralized characteristics thanks to the matrix organization)	Decentralized
Level of formalization	High	Medium	Low
Likely prerequisites for improvement	Improved management support and top-down communication	Implementation of a few Peer-Educators	Improved management support and commitment to Peer-Educators
Likely optimal KM approach	Top-down supporting Peer-to-peer	Top-down with a few active Peer-Educators	Peer-to-peer supported by internal community and intercom
Likely optimal reflected KM view	Process- and element view with a focus on element.	Process- and element view with a focus on element	Process- and element view with a focus on process

6.2 Conclusions

With reference to the above concluding discussion, we will in this section present the answers to our initial problem formulation, stated as followed:

ONE: How is the HIV related knowledge transfer, in terms of sharing, storing and using knowledge, perceived to work within the Wellness Program in company A, B and C, given:

(a) The choice of a peer-to-peer and/or top-down approach
(b) The reflected element and/or process view of knowledge
(c) The company specific context in terms of structure, culture and people

TWO: What are likely ways of improving the transfer of HIV related knowledge, given the specific prerequisites (a-c)

6.1.1 Conclusions Company A

(1) The current peer-to-peer approach and consequently process view of transferring knowledge seem to be somewhat failing judging by the poor results in terms of perceived attitudes, behaviour and performance of the Wellness Program. We would like to argue, with support from Davenport (1998), that one of the most likely explanations is a misfit in terms of chosen approach and consequently view in relation to the centralized and formalized context. (2) The knowledge transfer is likely to, given the company context, be improved by greater management support. Furthermore, the process view and element view should be applied coincidently with an emphasis on the element view of knowledge.

6.1.2 Conclusions Company B

(1) The current top-down approach and consequently element view of knowledge seem to be working well judging by good results in terms of perceived attitudes, behaviours and performances. The top-down approach is, with support from Davenport (1998) likely to fit with the company context of a somewhat centralized structure with low formalization. It is however also likely that a process view and consequently a peer-to-peer approach, with enough management support, would work well in addition to the chosen approach. (2) Our findings indicate that the Wellness Program could be improved by adding a few Peer Educators to support the information transfer. It is therefore likely that the process and element view should be used coincidently for the Wellness Program to be optimized.

6.1.3 Conclusions Company C

(1) The current mix of a top-down and peer-to-peer approach and consequently process- and element view of knowledge seem to be working quite well judging by the results of the perceived performance of the Wellness Program. However, in terms of perceived attitudes and behaviours, the knowledge transfer seems to be failing at some parts. We would like to argue that the most likely reason for this is that the company context which is decentralized and less formalized to its character, on one hand, with support from Davenport (1998) is likely to work better with a clean cut process view of knowledge transfer whilst the Wellness Program on the other hand currently lack the prerequisites to do so. (2) Our findings indicate that the Wellness Program could be improved by greater management support and commitment to the Peer-Educators. The process view and element view should to be applied coincidently with an emphasis on the process view of knowledge.

6.3 Theoretical Implications

On a theoretical level our goal was to contribute to a better and broader understanding of HIV-related knowledge transfer within Wellness Programs and more specifically, regarding the two knowledge transfer views; process view and element view.

As theory states, the element and process view of knowledge should not be taken as ideal types; any real organization is likely to display a combination of the two (Preuss & Cordoba-Pachoni, 2009). The findings from our study support theory in this regard, and in terms of a top-down and/or peer-to-peer approach this indicates that a successful Wellness Program is likely to require both in unison, adjusted to the specific company context occurring (Davenport 1998).

Our findings further imply that the company context is a crucial denominator in deciding what emphasis should be put on either the process view or the element view. Which furthermore supports Davenport (1998). The two KM approaches should not only be used in unison, but be carefully adapted to the occurring company contexts in order to optimize the Wellness Program.

Overall our study should be viewed as a catalyst from which interesting topics of future studies within the field of KM and more specifically the transfer of HIV-related knowledge, can be identified. This will be further elaborated on in the last section of this thesis.

6.4 Managerial Implications

On a managerial level our goal was set out to contribute to a better and broader understanding of how the knowledge transfer processes work given different company contexts and furthermore provide implications for how the knowledge transfer processes are likely to be improved.

Based on the findings in this study, we suggest that in order for the Wellness Program to be successful,

both an element and process view has to be applied. This means that the peer-to-peer and top-down approaches should not be treated in isolation to each other, but rather be seen as two components that have to be implemented in unison in order for the Wellness Program to reach maximum potential.

Our findings further imply the importance of creating a supportive structure to the Wellness Program internally, regardless of implementation of a peer-to-peer or top-down approach. Our findings does however imply that this becomes especially important when implementing a peer-to-peer program since the lack of management support has been shown to de-motivate both the sender and receiver of information. More specifically, this means that the managers has to support the Wellness Program and further increase the communication regarding who the possible Peer-Educators are and what can be expected from them.

Our findings further imply the importance of adjusting the KM approach to the occurring company contexts. This highlights the importance of the companies having a good understanding of the characteristics of their actual company context and what the consequences of the structure are. Our findings show proof of a discrepancy between what the company context might look like on paper and how they actually play out in practice. An implication is therefore that the companies should invest time and effort into analysing their specific company context in detail before deciding to what extent the element vs. process view should be applied. We would like to argue that this is particularly important in a multicultural environment, as displayed in many MNEs in South Africa.

Our findings further supports SWHAP's theory regarding the importance of having numerous employees responsible for the Wellness Program, and furthermore the problematic of having one or a few participants being too dominant. Our findings imply that the responsibility of the Wellness Program should be spread out among a few Peer-Educators/employees and/or managers with an equal amount of power in order for the Wellness Program to reach its full potential. Furthermore we would like to point out the importance for managing directors in companies who implement a peer-to-peer approach to understand that choosing the right Peer-Educators is crucial for a successful knowledge transfer. This since our findings imply that the characteristics of the Peer-Educator directly affects the performance of the transfer of knowledge both in terms of how active the Peer-Educator is but also in regards to the level of credibility the Peer-Educator has.

On a final note, we would like to argue that the findings in our study is not only applicable to the KM within a Wellness Program, but could also be relevant in terms of an organization's general KM strategies.

6.5 Critical reflections

6.5.1 Methodological

We have chosen to conduct a qualitative case study, which means that the generalizability of our findings is low. One could argue that the quality of the generated implications would be stronger if the empirical basis for them was more extensive. It is furthermore important to consider the findings of our study in relation to several limitations.

We consider one of the most crucial limitations in our study to be the cultural, ethical and social differences between us as researchers and the participants in our study. This might have caused our data to reflect incorrect facts. Furthermore the subject of Wellness and HIV cannot be disregarded of as a source of unreliable answers as the subjects are sensitive to many of the respondents, especially in their working environment.

It is also important to recognise that our study was limited by the amount of cases which not only limited the amount of factors that were examined but also produced a shortage of sampling facts for finding proofs (Yin, 1981). We therefore invite further research to develop and confirm the results of this study by introducing more cases and also possibly include a quantitative take to the knowledge transfer processes within inter-organisational Wellness Programs. However, as HIV is extremely sensitive and the study of knowledge and behaviour in regards to the virus is strongly related to psychological mechanisms of the human being we believe that the qualitative research method is preferable as it provides opportunities to gather the deeper insights needed.

We would further like to argue that the triangulation we have used had a positive impact on the results derived from the study as it was evident that the use of only one data-set would have lowered the reliability of our study. The primary and secondary data thus provided us with a more nuanced picture of the Wellness Program and the knowledge transfer taking place within its borders.

6.5.2 Theoretical

In terms of theoretical limitations, this study was set out to look at two specific, but related views of the knowledge transfer processes within the Wellness Program. Even though the reality consists of many more approaches and reflecting views to transferring knowledge, we did in this report limit the study to investigating the element and process view of knowledge in an organizational context.

6.6 Future Studies

We propose that the research we have conducted could be seen as a starting point for future research within the field of HIV related knowledge transfer within companies.

Since we only had a small number of case companies and respondents in our study, future research could further investigate if the identified implications are of general character by conducting quantitative studies. It could further be interesting to also look at other contexts, both in terms of geographical setting, type of company and even in other contexts beyond the corporate environment.

Future research could additionally focus on investigating the various elements of the proposed KM framework further. For example:

(1) Dig deeper into the enabling factors in the company contexts and try to truly understand what

enables knowledge transfer and more specifically what drives a desired behaviour. This could be done both in regards to HIV/AIDS related knowledge within Wellness Programs but also in regards to other subjects.

(2) Look at other views of knowledge and further other knowledge management approaches and how they correlate.

(3) Quantify the research on perceived intermediate outcome such as attitude and behaviour and thereby strive towards creating generalizable results. It could further be interesting to also look at other intermediate outcomes.

(4) Look at a more comprehensive numbers of performance variables to increase the level of reliability and further develop and formulate economic metrics in order to measure the financial impact of HIV/AIDS on the workplace. Consequently also measure in more rich detail the economic benefits of the Wellness Program. This we believe is highly important in order to motivate the Wellness Program's existence and furthermore to increase the internal support from managers which we, from our study, identified as a current problem.

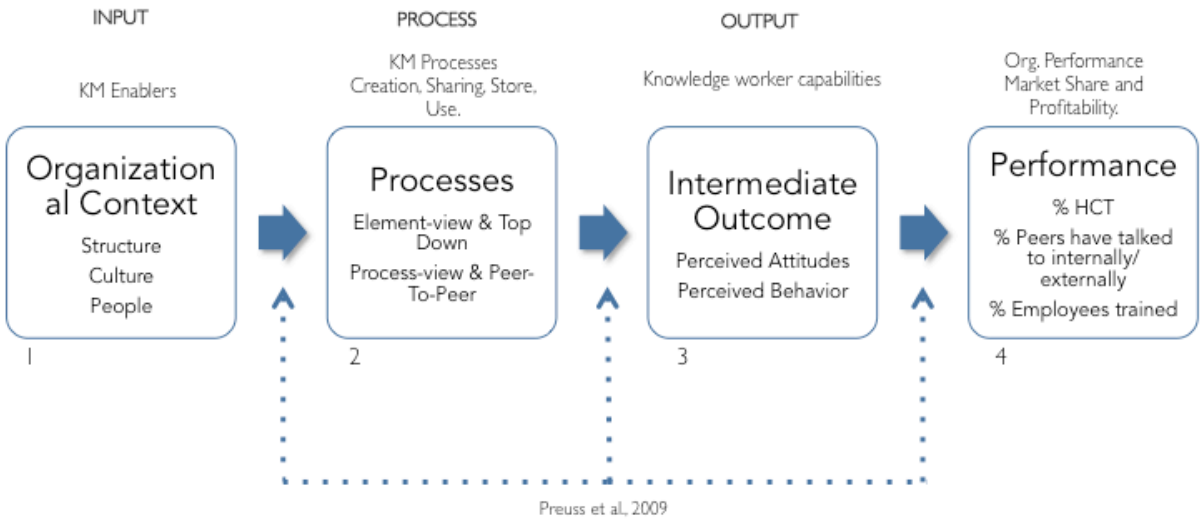


Fig. 4 Overview of Theoretical Model

In addition to the above proposed future research tied to the components that our study is built upon, we would like to suggest one last area for future studies beyond the frames of the research we have made. We started off this thesis by lifting the importance of MNEs to take global responsibility through facilitating a healthy development in society at large. After having done our research we would therefore like to suggest that future studies, should not only look at the implications that the Wellness Program has on it immediate environment i.e. the workplace. But also incorporate the effect that these initiatives can have on society at large. This to, once and for all, legitimize (or not) the role of the MNE as a mediator for positive change worldwide. On a final note, we care to agree with what the Swedish Prime minister says:

"There are opportunities here that the world cannot afford to ignore. Social justice is both ethically right and economically smart."

- Swedish Prime Minister Stefan Löfven, New York, USA 30 mars 2015

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Appendix I.

Abbreviations, Acronyms & Definitions

SIDA - Swedish International Development Cooperation Agency
SWHAP - Swedish Workplace HIV/AIDS Program
VCT- Voluntary Counseling and Testing
HCT – HIV Counseling and Testing
CSR - Corporate Social Responsibility
STD - Sexual transmitted diseases
MNE - Multinational Enterprise
HRA - Health Risk Assessment
HCT - HIV Counseling and Testing
LDC - Less Developed Country
PTG - Project Team Group
KM - Knowledge Management
KT - Knowledge Transfer
P-E - Peer-Educator

Definitions

Stigma: a set of negative and often unfair beliefs that a society or group of people have about something.[1]

AIDS: Acquired Immune Deficiency Syndrome. The cluster of conditions presented by HIV infected people, when the virus has progressed and started to reduce the body's defense (Liverpool VCT, care and treatment, 2009).

Antiretroviral therapy: Medication used to mitigate the effects of HIV, by reducing virus multiplication and strengthen the body's immune system, allowing it to recover enough to be able to withstand the infections of other diseases (Liverpool VCT, care and treatment, 2009).

HIV: Human Immunodeficiency Virus. The HIV-virus is a retrovirus, which implies that it has the ability of storing itself in the human genetics. An HIV-infection is an infection that one carries out through life, thus blood and other bodily fluids may be contagious during a lifetime (Liverpool VCT, care and treatment, 2009).

Wellness Program: In this report, the Wellness Program stand for an overarching program rolled out by SWHAP and The Reality Wellness Group, taking into account all health related issues in an organization, including the branch of specifically HIV/AIDS.

[1] http://www.merriam-webster.com/dictionary/stigma

Peer Educator: A peer is a person of the equal status and standing as another, sharing certain attributes and characteristics, for example, social rank, educational background, department, social status and age, with that someone. A Peer Educator, part of an HIV/AIDS Workplace Program is a volunteer who supports his peers at the workplace and the surrounding community to reduce their risk of HIV infection and transmission. A Peer Educator is also a person whom one can seek HIV services if infected and/or affected. The Peer Educators are not paid for their contribution, but get to attend seminars and workshops, with the aim of giving them tools and knowledge that they can spread forward (Liverpool VCT, care and treatment, 2009).

CD4 count: A CD4 count is a lab test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of a persons blood. In people with HIV, it is the most important laboratory indicator of how well your immune system is working and the strongest predictor of HIV progression.[2]

ARV: Standard antiretroviral therapy (ART) consists of the combination of different antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also prevents onward transmission of HIV.[3]

Centralization: Centralization refers to the locus of decision-making authority lying in the higher levels of a hierarchical relationship (Chung-Jen & Jing-Wen, 2007).

Formalization: Formalization refers to the degree to which jobs within the organization are standardized and the extent to which employee behavior is guided by rules and procedures (Chung-Jen & Jing-Wen, 2007).

[2]www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/cd4-count/
[3]www.who.int/hiv/topics/treatment/en/

Appendix II. INTERVIEW-GUIDE, (MANAGER)

PERSONAL (information gathered before interview):

- Age
- Sex
- Occupation
- Been in the company since…

FIRST QUESTION TO SET THE TONE: What are your general feelings about the Wellness Program? Do you think it is good or bad/How much do you value the program?

BACKGROUND TO PROGRAM / HIV/AIDS PROBLEM

1. What was the primary reason for implementing the program?
2. How is the procedure when HIV/AIDS is detected amongst employees?
3. According to you, what is the greatest contribution of the program?
4. Can you estimate how many of the employees that are infected by HIV/AIDS? How has this number changed since the program was implemented?
5. Is HIV/AIDS equally spread throughout the employees on all levels?
6. How do you communicate HIV related information due to the fact that the subject is very sensitive?
7. Has the level of productivity/motivation/moral/sick days changed since the program was initiated?
8. Who is in charge of health education and VCT/Projects at your organization?

THE INFORMATION TRANSFER PROCESS

We would like to start by talking about the way which information is spread regarding the "wellness program". There are no right or wrong answers, so please feel free to answer based on your own feelings and experiences.

SHARING KNOWLEDGE

1. In what form do you share information about the wellness program? (Verbally, in documents, through policies, online or in multiple ways?)
2. What are your feelings about this?
3. Would you prefer to share the information in any other way?

4. How often is information about the wellness program shared?
5. Do you feel that there is enough information shared about the wellness program?
6. How often do you "receive" information about the Wellness program from RWG?

7. What do you think is the goal with the wellness program? The reason behind it?
8. Do you think the wellness program reaches that goal?

Sender: Motivation, ability to estimate prior knowledge.

1. What motivates you to participate in the communication of the program? Why do you participate in the health program (as a peer or top-down communicator)?

2. How do you feel about the employees taking in information - are the interested/enthusiastic about it, or do you rather have to "push" the information on them?
3. Would you say that the employees are aware and informed in regards to health/HIV/AIDS?
4. Do you believe that the information/knowledge that you spread is important and valuable? To whom?

STORING KNOWLEDGE

1. Where can employees find information about the wellness program, if they want to search for it themselves (policy, documents, intranet)?
2. ((How do you feel about the way the information is being stored?))
3. Is it easy/hard to find information about the program?
4. Is there enough information "stored" about the Wellness program (if you want to look up something in private - can you)?

5. Do you keep a log of the information sessions you hold (Peer educators/top down managers)?

USE OF KNOWLEDGE

1. Do you read any additional information that is not verbally communicated?
2. Have you talked to others (friends/family) about health related questions?
3. What are your feelings about talking about that?
4. Do you live a more healthy life after initiating the program, in what ways?
5. What are your feelings towards working with the health program?

REGARDING THE COMPANY CONTEXT

The Structure: understand if the structure is centralized/decentralized and formalized or not!

Centralized or Decentralized?

1. Who (one or many) would you say has the greatest "power to decide" in the company? Why is that?
2. Are there forums in which people who are not managers can express their thoughts on how things are being handled in the organization?
3. Would you say that you have much/little freedom to decide what you should do and prioritize during a working day?

Formalization: Understand to what degree is your work governed by rules, standard policies, and procedures?

1. Are you controlled/monitored when working? By who? Why?
2. Are you free to come up with new ways of handling your work?
3. Do you think that there are a lot of rules to follow?
4. Would you like to have more or less flexibility in your work?
5. Does the company have one/more information sources? (intranet, managers, newsletters etc.).

The Culture: Understand the company culture; Collaborative culture? - Is/in what ways does the company work to reduce fear and increase openness at the workplace?

1. Are you ever afraid at work? When and why?
2. Do you feel that you can express whatever is on your mind whenever to everyone in the organization?

Risk-taking: Is/in what ways does the company encourage new ideas and risk taking?

1. Do you take own initiatives at work? What would you do if you come up with an idea? Who do you turn to?
2. Do you feel that your ideas are being heard?
3. Can you act on any new ideas you have in regards to the way you perform your work?

Learning culture? Does people have positive orientation to knowledge?

1. Do you like learning new things?
2. Do you think that your colleagues like learning new things?
3. Do you think that your managers like learning new things?
4. If you learn something new, do you like to share it with others?

How important is it to share information that you get with others on the workplace?

1. Would you say that you learn most from your peers (colleagues)/ your managers/ your HR-manager or someone else?

To what degree is the company supporting individual learning and development?

2. Have you had the opportunity to attend any "education/ courses" or further educate yourself at work? What/when/why?
3. Are there any training, mentoring and peer training occurring?
4. How often would you estimate that you get a chance to learn something new? Every day? Once a week? Once a month?

The People: Understand degree of support + trustworthy environment + skills

1. Do you usually help colleagues that need help in some way?
2. How often do you ask for help from your colleagues? Manager? Do you get it then?
3. Do you feel safe at your workplace?
4. To what degree does people have faith in others' intention and behaviors?
5. Do you trust your colleagues?
6. Do you trust your manager?
7. Are you ever afraid of losing your job? Why is that?
8. To what degree would you say that people exchange knowledge within the organization before taking decisions? Do you ask for people's advice before making a decision?
9. To what degree do you feel comfortable in your competence level?
10. Do you feel comfortable with your work tasks and level of responsibility?
11. Does your work tasks challenge you? Eg. are they difficult to perform or easy?

Appendix III. INTERVIEW-GUIDE (EMPLOYEE)

PERSONAL (information gathered before interview):

- Age
- Sex
- Occupation
- Been in the company since…

THE INFORMATION TRANSFER PROCESS (ALL):

We would like to start by talking about the way which information is spread regarding the "wellness program". There are no right or wrong answers, so please feel free to answer based on your own feelings and experiences.

FIRST QUESTION TO SET THE TONE: What are your general feelings about the Wellness Program? Do you think it is good or bad/How much do you value the program?

SHARING: DISTRIBUTION AND TRANSFER

1. In what form do you share information about the wellness program? (Verbally, in documents, through policies, online or in multiple ways?)
2. What are your feelings about this?
3. Would you prefer to share the information in any other way?
4. How often is information about the wellness program shared?
5. Do you feel that there is enough information shared about the wellness program?
6. How often do you "receive" information about the Wellness program from RWG?
7. What do you think is the goal with the wellness program? The reason behind it?
8. Do you think the wellness program reaches that goal?

→ Do you mainly consider yourself being a sender of information or a receiver of information in the program?

IF Sender (peer-educator): Motivation, ability to estimate prior knowledge.

1. What motivates you to participate in the communication of the program? Why do you participate in the health program (as a peer or top-down communicator)?
2. How do you feel about the employees taking in information - are the interested/enthusiastic about it, or do you rather have to "push" the information on them?
3. Would you say that the employees are aware and informed in regards to health/HIV/AIDS?
4. Do you believe that the information/knowledge that you spread is important and valuable? To whom?
5. Do you feel motivated to take part of the program? Why?
6. Would you say that you actively seek information or that it rather "comes to you without you having to seek or ask for it?" *
7. Would you say that you have bad/moderate/good knowledge in regards to health?

STORING KNOWLEDGE

1. Where can employees find information about the wellness program, if they want to search for it themselves (policy, documents, intranet)?

2. ((How do you feel about the way the information is being stored?))
3. Is it easy/hard to find information about the program?
4. Is there enough information "stored" about the Wellness program (if you want to look up something in private - can you)?

USE OF KNOWLEDGE

1. Do you hold information sessions to your fellow colleagues? (Peer educator)
2. If so, what are your feelings about being a spokes person/change agent?
3. Have you talked to others (friends/family) about health related issues?
4. What are your feelings about doing that?
5. Do you live a more healthy life after initiating the program, in what ways?
6. What are your feelings towards being a part of the PTG?

REGARDING THE COMPANY CONTEXT

The Structure: understand if the structure is centralized/decentralized and formalized or not!

Centralized or Decentralized?

1. Who (one or many) would you say has the greatest "power to decide" in the company? Why is that?
2. Are there forums in which people who are not managers can express their thoughts on how things are being handled in the organization?
3. Would you say that you have much/little freedom to decide what you should do and prioritize during a working day?

Formalization. Understand to what degree is your work governed by rules, standard policies, and procedures?

1. Are you controlled/monitored when working? By who? Why?
2. Are you free to come up with new ways of handling your work?
3. Do you think that there are a lot of rules to follow?
4. Would you like to have more or less flexibility in your work?
5. Does the company have one/more information sources? (Intranet, managers, newsletters etc.).

The Culture: Understand the company culture

Collaborative culture? Is/in what ways does the company work to reduce fear and increase openness at the workplace?

1. Are you ever afraid at work? When and why?
2. Do you feel that you can express whatever is on your mind whenever to everyone in the organization?

Risk-taking? Is/in what ways does the company encourage new ideas and risk taking?

1. Do you take own initiatives at work? What would you do if you come up with an idea? Who do you turn to?
2. Do you feel that your ideas are being heard?
3. Can you act on any new ideas you have in regards to the way you perform your work?

Learning culture? Does people have positive orientation to knowledge?

1. Do you like learning new things?
2. Do you think that your colleagues like learning new things?
3. Do you think that your managers like learning new things?
4. If you learn something new, do you like to share it with others?

How important is it to share information that you get with others on the workplace?

1. Would you say that you learn most from your peers (colleagues)/ your managers/ your HR-manager or someone else?

To what degree is the company supporting individual learning and development?

2. Have you had the opportunity to attend any "education/ courses" or further educate yourself at work? What/when/why?
3. Are there any training, mentoring and peer training occurring?
4. How often would you estimate that you get a chance to learn something new? Every day? Once a week? Once a month?

The People: Understand degree of support + trustworthy environment + skills

1. Do you usually help colleagues that need help in some way?
2. How often do you ask for help from your colleagues? Manager? Do you get it then?
3. Do you feel safe at your workplace?
4. To what degree does people have faith in others' intention and behaviors?
5. Do you trust your colleagues?
6. Do you trust your manager?
7. Are you ever afraid of losing your job? Why is that?
8. To what degree would you say that people exchange knowledge within the organization before taking decisions? Do you ask for people's advice before making a decision?
9. To what degree do you feel comfortable in your competence level?
10. Do you feel comfortable with your work tasks and level of responsibility?
11. Does your work tasks challenge you? Eg. are they difficult to perform or easy?

Appendix IV. Background to program, Company A, B & C

In the below section the background to why the program was first initiated in the three companies will be presented to provide the reader with a contextual snapshot of how history has impacted the current program set up and why certain features of them have evolved and some not. This section is derived from interviews with one individual on each company who has extensive knowledge and experience of the HIV/AIDS program.

Company A

The Wellness Program at Company A was initiated in 2004 after SWHAP had presented their work to the management team. Company A had already recognized the problem of HIV/AIDS and the impact it had on the effectiveness of their working force and overall business, but were at that point in time puzzled in terms of finding a solution to the problem, which made the proposal by SWHAP very appreciated.

Company A focused solely on HIV from start, but incorporated more general health related issues as the program progressed. They did see quite fast results in terms of employees becoming more aware immediately after initiating it. After some years, absentees and sick days were reduced and they could further see a clear improvement tied to time spent of work to do testings' at government and/or private clinics as well as attending funerals. Company A states that the rate of infected individuals was high when the Wellness Program was first rolled out, however during the last six years the rate of new infections has decreased.

When the program was first initiated there was a severe stigma concerning HIV/AIDS in the organization. People were afraid, they were not used to talking about it and thought that getting the virus would definitely kill them. They also believed that they might be discriminated or even fired if their employer would find out that they had HIV. This has changed now and people are much more open to talking about foremost HIV but also other health related issues in the organization. According to Company A the reason to why the program was so successful at start was the extensive use of Peer-Educators. People really relied on the "peers" who did a great job in communicating and sharing knowledge with their co-workers. "When people feel that they can trust the source of information and when they get to meet with people on the same level it is easier for them to share their concerns - especially when it comes to HIV and sex generally".

Company A still works with peer-educators but since a couple of years back, the budget for the program has been cut. This fact, together with other circumstances such as internal reorganizations, has made the management less involved in the program. This has lead to Peer-Educators not getting as much support anymore which in turn have had a negative influence on the effectiveness of the Wellness Program. They do however still maintain a Wellness Committee as recommended by SWHAP and arrange one Wellness Day a year with HIV testing as well as full health check-ups.

Company A has six peer-educators in the head office and two in the factory. At present there is 38 HIV positive employees in the company. The HIV positive employees are divided equally on different levels in

the organization according to Company A who further reveals that the general perception among the white-collar workers is that it is foremost people working in the plats who are affected.

Company B

The reason to why Company B first initiated the Wellness Program was an internal problem with HIV and AIDS in the organization. The management team saw a need to talk more openly about the disease to increase the number of tests and thereby decrease the number of sick-days and reach a higher productivity among the employees. The interest in the program was great from start.

The program carried on with great success during a few years. Company B even initiated their own rewards systems where employees, based on engagement in various Wellness Program related activities could earn rewards. As time passed by, the program slowly began to shift focus from pure HIV/AIDS related communication and focus, to an overall focus on wellness. This is furthermore the general Wellness focus, with full body testings' during Wellness days, which the Wellness Program still incorporates at Company B.

During the first years of the Wellness Program, Company B could proudly present numbers that showed zero employees that first tested negative for HIV and then tested positive (while still at the company). However, four years ago, Company B had the first cases where people that previously had tested negative for HIV, tested positive. The numbers were taken very seriously and was perceived as a wake-up-call to put more emphasis on HIV again.

Today, Company B offer all employees the possibility to attend the Wellness Days twice a year, with full body testings' as well as HIV testing''. Generally, Company B does not treat HIV related information different than any other Wellness related information or disease. The HR representative emphasizes the importance of working against the HIV stigma and talk about the sickness openly.

Company B explains that they believe the biggest contribution of the program to be the education of staff. They explain that today, the Company B employees know more about their Wellness than before, they know about HIV and they talk more openly to each other about the disease. This has helped people to become healthier which is evident on rate of sick leave and overall productivity at work.

The Company B program follows a "Top-Down Approach" where most of the power lies within the HR department. The reason to why they have chosen to not implement a peer-educator system is because of bad experiences with such an approach. Company B tried working with peer-educators a few years ago, according to themselves without any success. The HR department did not feel comfortable with the fact that a lot of information and thereby power was distributed on the employees and beyond the HR department's control. "I'd rather see an educated nurse responsible for distributing wellness related information among the Company B employees".

A final note to the background at Company B is that the program not only follows a typical "Top-Down approach" at the company, but furthermore that Company B does not have a Wellness Committee as recommended by SWHAP. The HR representative controls most of the program alone together with The Reality Wellness Group.

Company C

Company C first initiated the Wellness Program as they had experienced internal problems related to various illnesses, such as HIV and diabetes. The company, at that time had a culture where few employees talked about wellness and above all had little knowledge about their own wellness conditions. The Wellness Program was implemented with the hope of educating the employees about wellness in order to make the employees start talking, decrease the cases of illnesses and thereby improving the overall level of productivity at Company C.

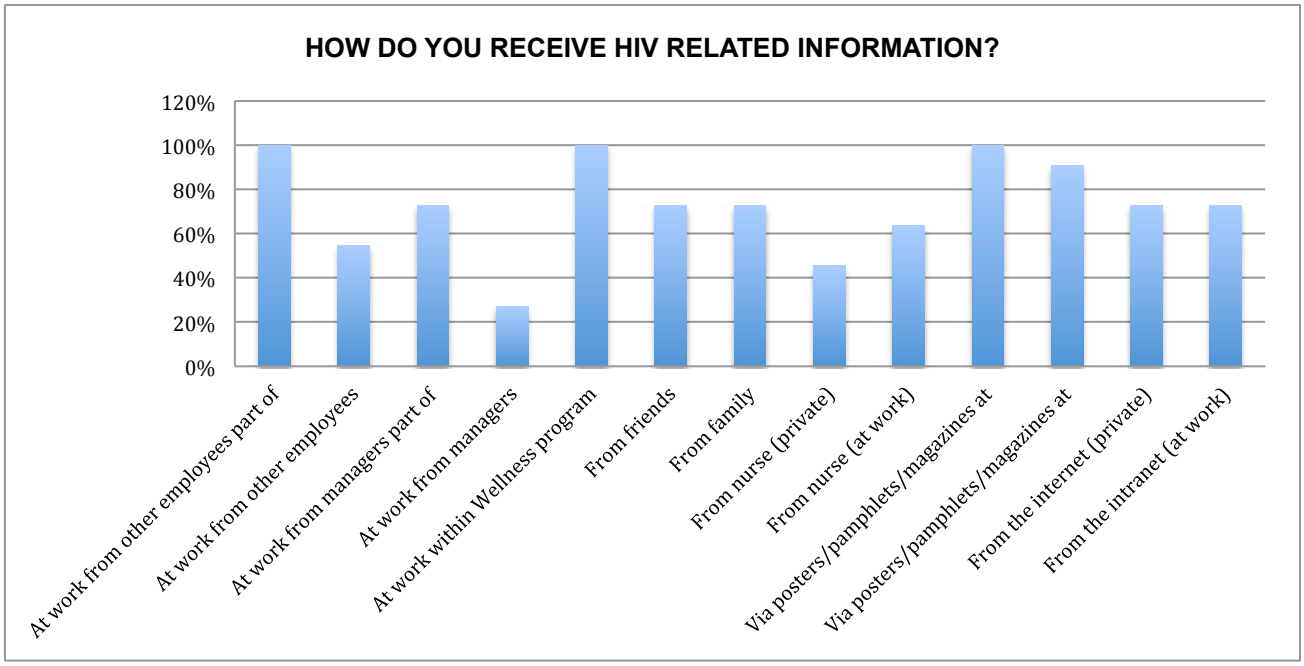
When the program was implemented, alot of time and effort was put into establishing a "Peer-to-peer approach" to the program. After some years, SWHAP no longer contributed to financing the program and today there are fewer Peer-Educators among the staff than before. They do however still have an active "Committee" as recommended by SWHAP and arrange two Wellness Days a year with HIV testing as well as full health check-ups.

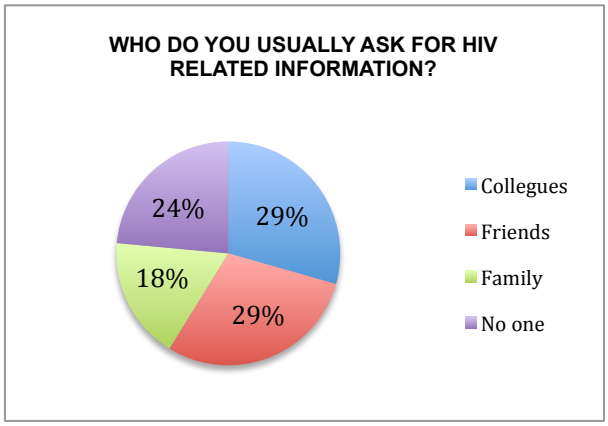
Company C says that the greatest contribution of the program is the improved knowledge that the employee's have in terms of their personal health conditions. It has improved both health and productivity amongst the employees, which has furthermore resulted in better productivity and commitment from both management and employees.

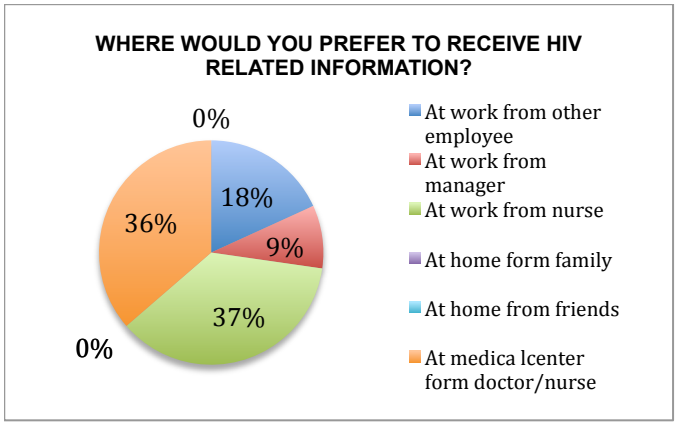
Today, the program does not only focus on HIV questions and communication, but has a general Wellness focus. Representatives of the program explain that the program has helped employees that suffer from everything from depression to alcoholism and grief. Once a month, the Company C headquarters is visited by a wellness counselor that the employees can reach out to if they want to. Something that Company C believes is very appreciated by the employees.

Appendix V. Additional Charts, Company A, B & C

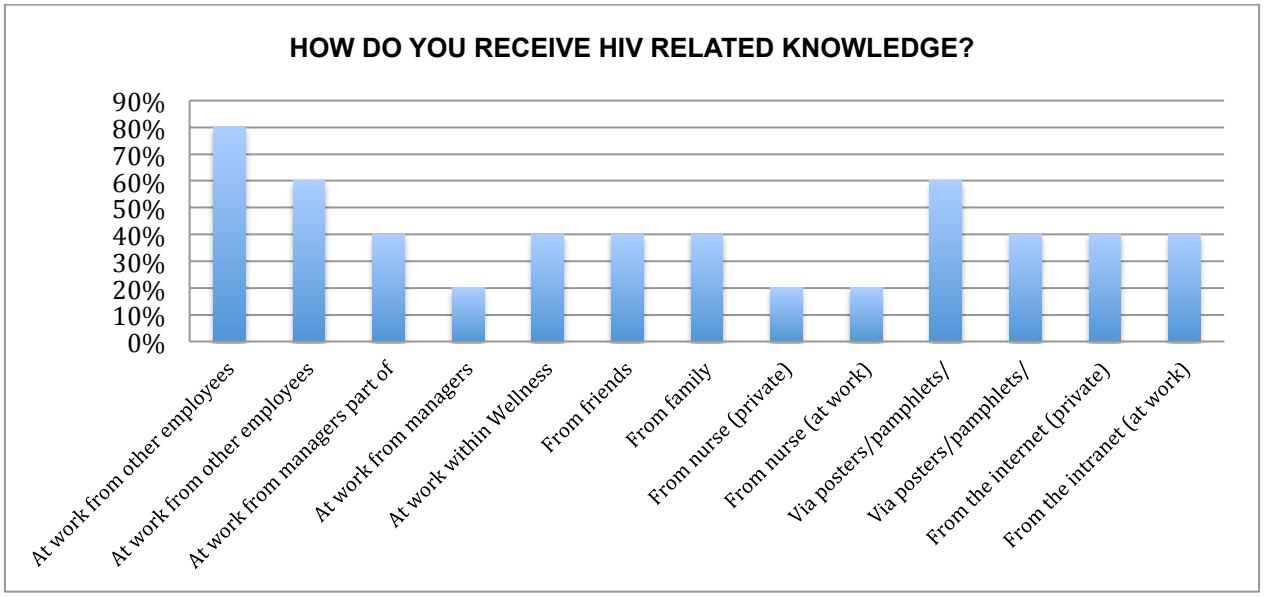
COMPANY A

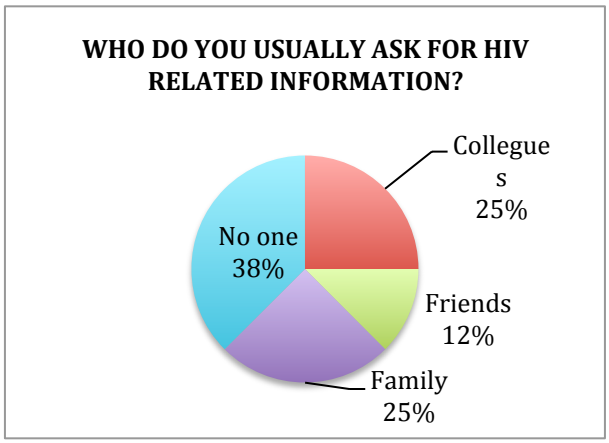


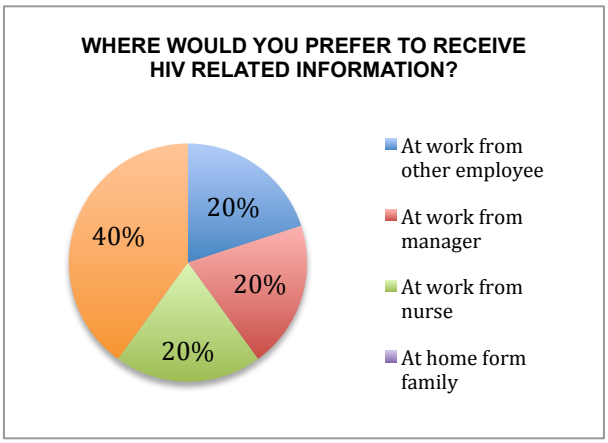




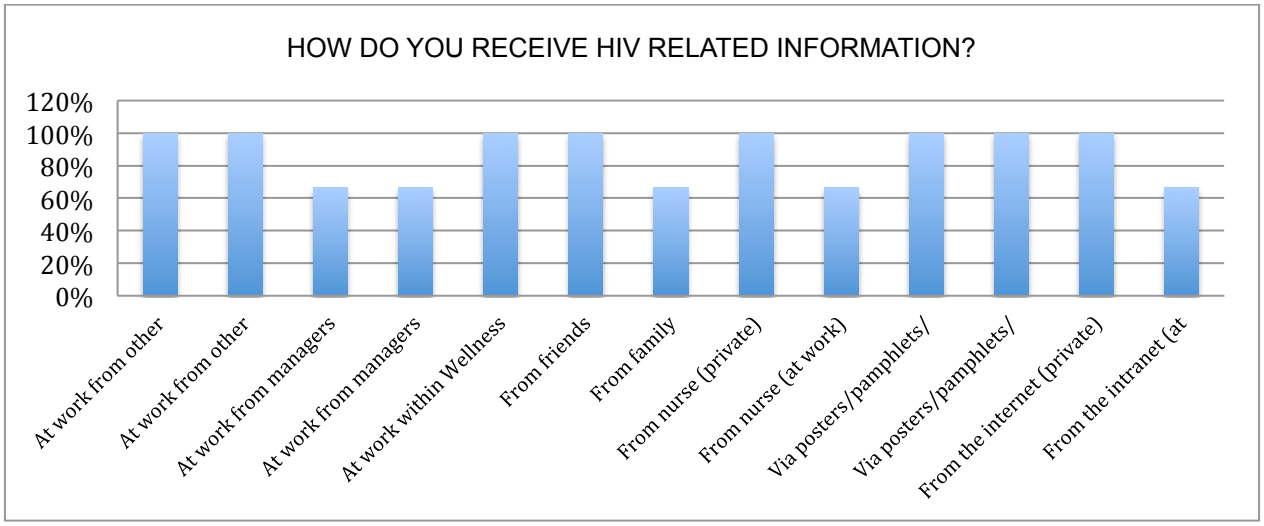
COMPANY B

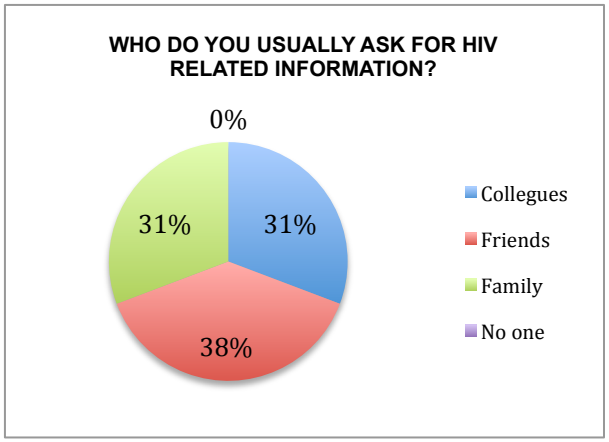

HOW DO YOU RECEIVE HIV RELATED KNOWLEDGE?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
At work from other employees
At work from other employees
At work from managers part of
At work from managers
At work within Wellness
From friends
From family
From nurse (private)
From nurse (at work)
Via posters/pamphlets/
Via posters/pamphlets/
From the internet (private)
From the intranet (at work)

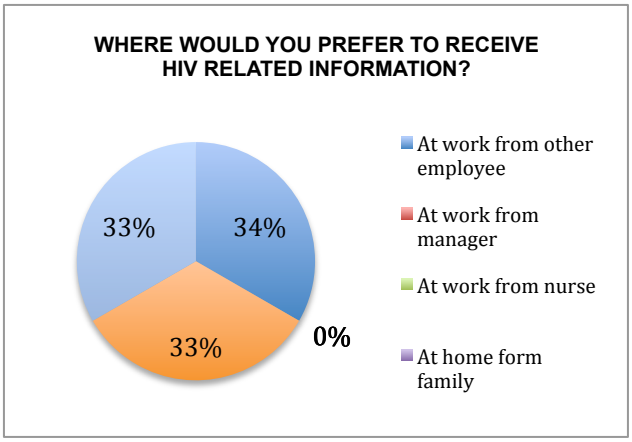

WHO DO YOU USUALLY ASK FOR HIV RELATED INFORMATION?
Collegue s 25%
No one 38%
Friends 12%
Family 25%


WHERE WOULD YOU PREFER TO RECEIVE HIV RELATED INFORMATION?
20%
20%
20%
40%
At work from other employee
At work from manager
At work from nurse
At home form family

COMPANY C


HOW DO YOU RECEIVE HIV RELATED INFORMATION?
120%
100%
80%
60%
40%
20%
0%
At work from other
At work from other
At work from managers
At work from managers
At work within Wellness
From friends
From family
From nurse (private)
From nurse (at work)
Via posters/pamphlets/
Via posters/pamphlets/
From the internet (private)
From the intranet (at


WHO DO YOU USUALLY ASK FOR HIV RELATED INFORMATION?
0%
31%
31%
38%
Collegues
Friends
Family
No one


WHERE WOULD YOU PREFER TO RECEIVE HIV RELATED INFORMATION?
33%
34%
33%
0%
At work from other employee
At work from manager
At work from nurse
At home form family