CHAPTER 3
ORGANIZATION AND SITUATION PROFILE

3.1 Indonesia Health Priorites and Programmes

The Health Law number 23, enacted in 1992, provided the legal basis for health sector activities which stipulated that the goal of health programmed and development is to increase awareness, willingness and ability of everybody to live a healthy life. The law emphasizes the decentralization of operational responsibility and authority to the local level as a prerequisite for successful and sustainable development. In 2000, the People's Assembly (MPR) amended the 1945 Constitution of the Republic of Indonesia to include the right of every citizen to live in a healthy environment and have access to health services and social insurance. In mid-September 1998, a new health paradigm was introduced that focused more on health promotion and prevention rather than on curative and rehabilitative services. The new vision was reflected in the motto "*Healthy Indonesia 2010*" with development plan which outlined the following goals:

- lead and initiate health-oriented national development;
- maintain and enhance individual, family, and public health, along with improving the environment;
- maintain and enhance the quality, equitability and affordability of health services
- Promote public self-reliance in achieving good health.

In March 2006, the Ministry of Health issued a new Strategic plan 2005-2009 emphasizing the new vision *"self reliant communities to pursue healthy living"* and its mission *"to make people healthy"*.

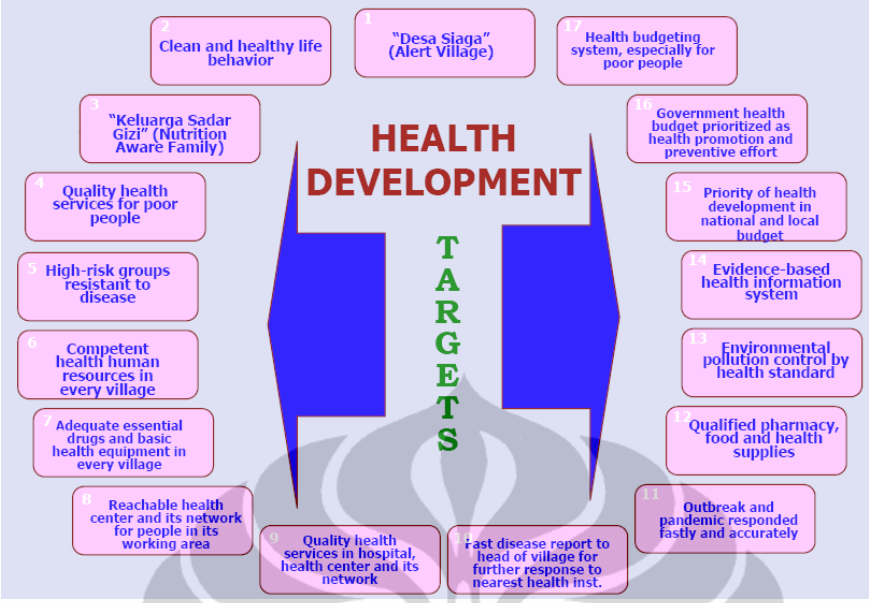

Figure 3.1 Health Development Targets

Source from Ministry of Health Annual Report (2008)

The four pillars or priorities that form the basis of the new health approach are:

- Social mobilization and community empowerment, including promotion of proactive participation of individuals and communities in their own health care and the promotion of the desa siaga (village preparedness programmed).
- Improvement of community access to quality care services through revitalization of the basic health system, development of effective and efficient networks, implementation of health sector quality assurance and improvements in the number and quality of human resources. Increasing access and quality of health care should be supported by adequate healthy administration, laws and regulations as well as health research and development.
- Improvement of surveillance, monitoring and health information system through active community participation in reporting health problems, mobilization of funds and human resources in emergency situations, improvement of early warning system and implementation of the national pandemic preparedness plan. Health information systems at all levels need to be revised and strengthened.

- Increase in health financing through identification of funds to ensure availability of resources for health; advocacy to all stakeholders in both public and private sectors; gradually increasing public financing to 15% from national and regional state budgets. Furthermore, social health insurance will be extended, starting with the implementation of a programme providing subsidized insurance for the poor.

3.2 Indonesia Health Profile

Indonesia is currently experience an improvement in socioeconomic indicators. Life expectancy at birth reached 69.09 years in 2007 and the infant mortality rate gradually declined from 68 per 1000 in 1990 to 34 per 1000 in 2007. The proportion of population living in poverty dropped dramatically from 60% in 1970 to a 14.15% in 2009. Maternal mortality rates in 2007 was 228 per 100000 live births which can be considerably reduced through quality health prevention and care. There has been a decline in fertility in Indonesia from 3.0 children per woman of reproductive age in 1988-1991 to 2.177 children per woman in 2007. Compared with some countries in South-East Asia, the total fertility rate in Indonesia is relatively low and a decline has taken place in most provinces.

Communicable diseases such as Malaria, Tuberculosis, Denge Fever, Polio, continue to be the major cause of morbidity and mortality in Indonesia. Mal and undernutrition also consider as a major cause of mobidity and mortality. Basic health survey 2007 indicates that prevelance of mal nutrition was 13%. There were 21 provinces with prevalance of mal nutrition above the percentage. Meanwhile over nutrition prevalence in Indonesia was 4.3%.

Malaria remains a major vector-borne disease in many parts of Indonesia. However since Gebrak Malaria (Roll back malaria) initiative in 2000, Malaria incidence rate tends to decrease. In 2008, API decreased to 0.61 from 0.81 in 2000 and in line with that, siginificant progress AMI in 2008 also decreased to 17.77 from 31.09 in 2000. National target by 2010, number of malaria sufferer would be 5 per 1000 population. For dengue fever, in 2008 there were 136,333 cases and CFR 0.86%. The incidence rate was 60.06 per 100.000 population.

Table 3.1 Economic Indicator of Indonesia

Total Population (2010)	234.2 Million
Population Distribution % Rural (2010)	53.7
Life Expectancy at Birth (2008)	70.5
Under-5 mortality rate per 1000 (2007)	44
Maternal mortality rate per 100,000 live births (2007)	228
Total Expenditure on health as % of GDP (2005)	2.7
General Government expenditure on health as % of general government expenditure	5
Human Development Index (rank out of 1777 contries, 2009)	111
Gross National Income per capita USD (2008)	1880
Adult (15+) literacy rate (2000-2007)	92.24
Adult Male (15+) literacy rate (2000-2007)	95.4
Adult Female (15+) literacy rate (2000-2007)	89.1
% Population with access to improved drinking water source (2009	47.63
% Population with improved access to sanitation	51.02

Source from WHO Country Cooperation Strategy 2007 - 2011

The rate was lower than that of 2007 at 71.78 per 100.000 population due to the significant implementation of PSN (pemberantasan sarang nyamuk = mosquito nest elimination) through 3M plus (Menguras = draining and cleaning reservoir; Mengubur = burying unused things that can keep water; Menutup =

closing reservoir) plus pouring larvicide, placing fish inreservoir and other efforts that can prevent/combat Aedes Agypti to breed.

Figure 3.2 Incidence Rate of Dengue Fever in 2008

Source from DG of DC and EH Ministry of Health (2008)

The HIV epidemic directly affects the most productive members of the society: the young people and wage-earners. By December 2008, number of people with HIV were 6,015 and people with AIDS were 16,110, increasing from 4700 people in December 2005. Based on the report from Ministry of Health, in 2008, province with the highest AIDS case rate was Papua at 129.35 per 100.000 followed by Bali at 33.75 and DKI Jakarta at 30.52.

3.3. Indonesia Health Care System

The general decentralization process implemented in 2001 has had many impacts on the health system, even though it was not designed specifically with the health sector in mind. In particular, health financing, health information systems, human resources for health and service provision have been affected. Under decentralization, the responsibility for health care provision is largely in the hands of regional governments. Several type of health care provision are Health Care Center (Puskesmas), and Hospitals based on ownership. Health center is a technical implementer unit of municipality / district health office in sub district or hamlet area implementing operational task of health development. There were 8.234 health centers in Indonesia in 2007 while the ratio of health center to

100,000 population was 3.65, it means that every 3-4 health centers gave services to 100,000 population.

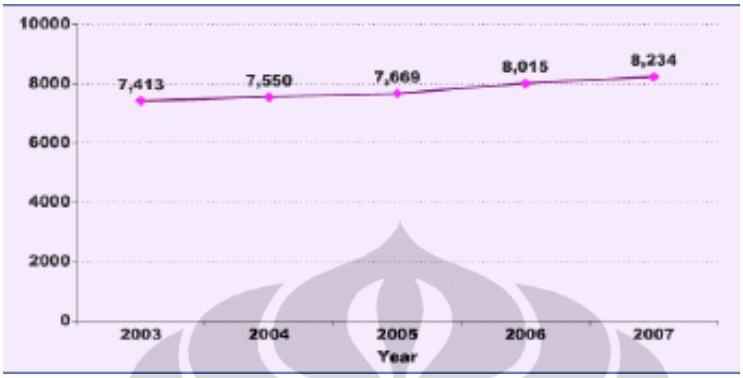

Figure 3.3 Number of Health Center in Indonesia

Source from Center for Data and Information, Ministry of Health (2008)

Hospital is a facilites that organizes the efforts of health-care activities such as outpatient services, inpatient services, emergency care services including medical services or medical support, and can be used for health education and research. In Indonesia, hospitals can be categorize based on their type or the ownership. Based on the type, it can be categorized as follows:

- Public Hospital (RSU), provide health services to all types of diseases from basic to the sub-specialist.
- Asylum (RSJ), specialized hospital services for those who are mentally challenge.
- Spesific Hospital (RSKh), hospitals that carry out health care based on an illness or specific disciplines
  a. Leprosy Hospital (RSK)
  b. Lungs Tubercholosis Hospital (RSTP)
  c. Eyes Hospital (RSM)
  d. Orthopedy Hospital (RSO)
  e. Maternity Hospital (RSB)
  f. Other Spesific Hospitals such as Cancer Hispitals, Hospital for Dhermatology, Heart Center, etc.

While based on the owner, we can categorize a hospital into:

- Vertical Hospital, own by Ministry of Health
- Pemda Pro Hospital, own by loca province government
- Pemda Hospital, own by city or district government
- TNI and Polri Hospital
- Other Department or BUMN Hospital
- Private Hospital

Public hospital own by the government can be further classify based on their capacity level:

- RSU class A, general hospital that have wide facilities and capabilities, medical service specialist and sub specialist area.
- RSU class B, general hospital that have limited facilities and capabilities, medical service specialist and sub specialist area.
- RSU class C, general hospital that have at least 4 complete basic specialistic (surgery, internal surgery, child health dacilities, maternity and gynechology).
- RSU class D, general hospital that have facilities and capabilites with at least basic medical service.

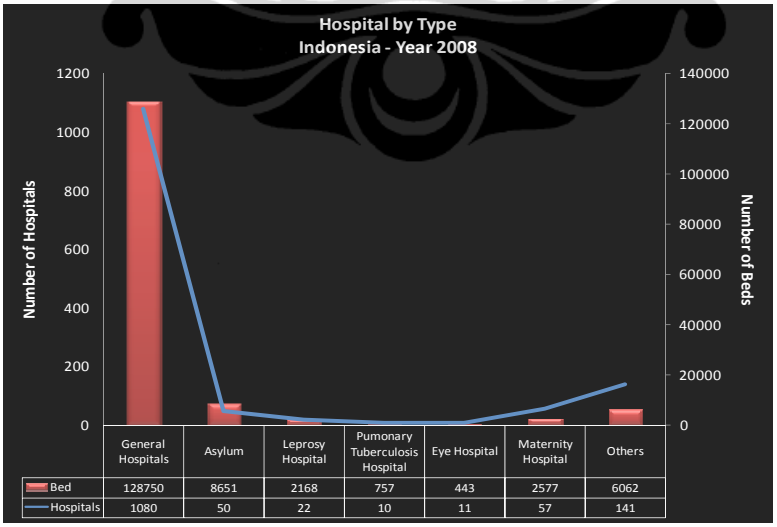

Figure 3.4 Hospital by Type in Indonesia for 2008

Source from Daftar Rumah Sakit di Indonesia by Ministry of Health (2009)

From 1371 hospitals in Indonesia based on the data from the year 2008, 78.8% of it is public hospital (1080) with bed capacity of 128.750 (86.2%). All over Indonesia there are still 25 RSU with less than 25 number of beds and 290 RSU with number of beds between 25 – 50. Only 10 RSU with 500 – 1000 number of beds and only 1 RSU thay have more than 1000 beds. If we look further down to DKI Jakarta statictic, there are 124 hospitals and 16,892 number of bed. The ratio for bed capacity compare to the population here is the smallest when compare with the other province. In DKI Jakarta, the ratio is 1:154, which means that 1 bed in a hospital can be use for 154 people.

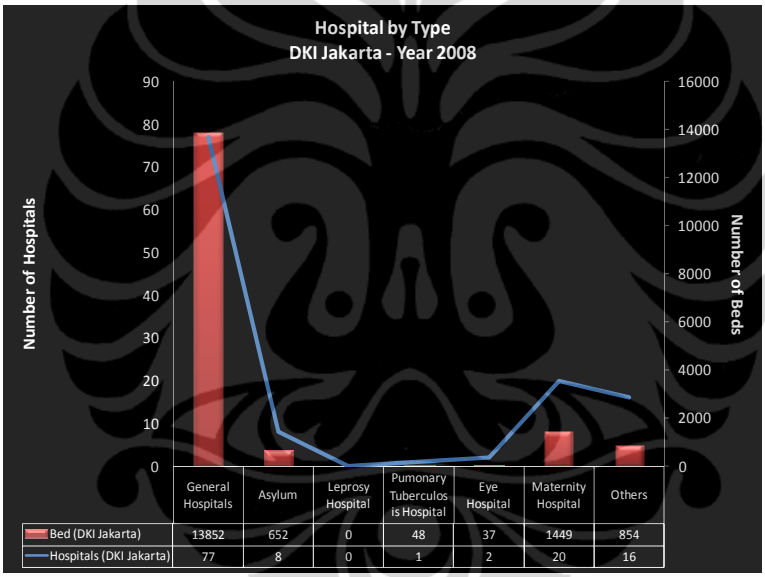

Figure 3.5 Hospital by Type in DKI Jakarta for 2008

Source from Daftar Rumah Sakit di Indonesia by Ministry of Health (2009)

From 77 pubic hospitals in DKI Jakarta, 8 own by the government, only 10.39%, while most of it own by private. This small percentage of hospitals is the not-for-profit organization that are going to be describe further in the next chapter. How they can survive, grow and gradually enhance their service delivery when their competitor is mostly from private sectors who are mostly profit-oriented organization who has a comprehensive strategy.

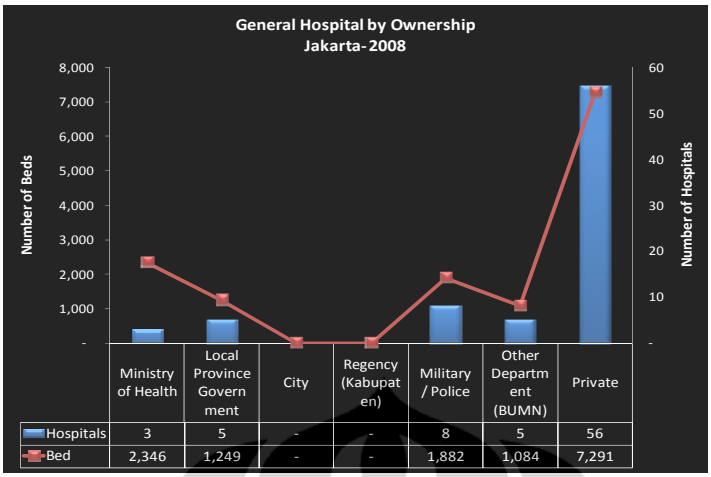

Figure 3.6 Public Hospital by Ownership in DKI Jakarta – Year 2008

Source from Daftar Rumah Sakit di Indonesia by Ministry of Health (2009)

Currently government own 432 hospitals all over Indonesia, and from it only 8 hospitals classify as A class, 82 B class, 260 C class and 81 D class. Further more, DKI Jakarta only has 1 hospital in A class while most of the RSU is in B Class and 1 hospital in C class. RSUD Koja is classify as B class. From those hospitals, only 8% distribution of room is VIP room, 8% for first class, 25% for second class, 55% for third class and 4% without class.

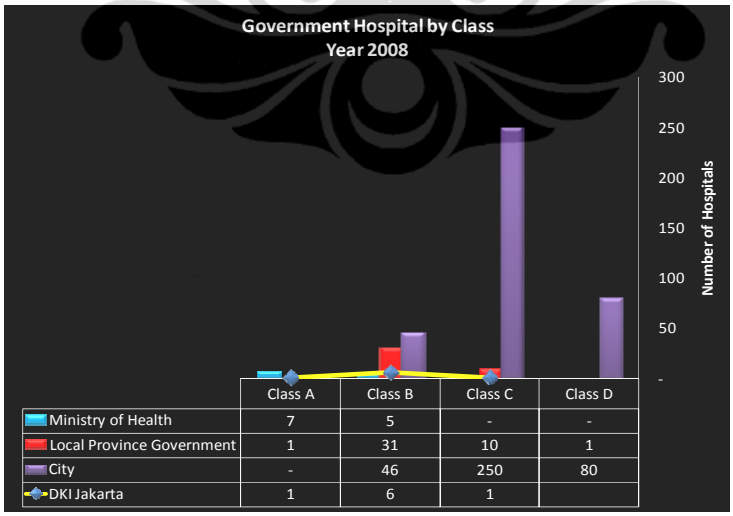

Figure 3.7 Government Hospital by Class for 2008

Source from Daftar Rumah Sakit di Indonesia by Ministry of Health (2009)

3.4. RSUD Koja History

RSUD Koja was built in August 8th 1952 by the former Governor of DKI Jakarta Mr. Syamsurizal. Initially, it was built just as a clinic and maternity hospital which then eventually become a public hospital. In 1997, Government stipulate RSUD Koja as a class C hospital because there were already 4 basic medical service such as surgery, child care, internist and maternity. Officially in 1984 through Peraturan Daerah DKI Jakarta No. 1.1984, RSUD Koja establish as Technical Implementation Unit (Unit Pelaksana Teknis) for Dinas Kesehatan DKI Jakarta (Local Official of Health). Throghout this past years, RSUD Koja has been develop as the hospital for education and training or research. RSUD Koja enacted into provincial health department unit area of Jakarta that fully implements the KDP BLUD through DKI Jakarta Governor's Mandatory (SK No.2010/2006). The implementation of this mandate cause a lot of changes that includes the entire process of work program activities. Financing system of local government subsidies will be decrease gradually resulting in the need for a careful calculation of budget planning activities in the future.

3.5 RSUD Koja Vision and Mission

RSUD Koja owned by local governments that implement all regulations and other measures as work units (BLUD). To comply with DKI Jakarta's mission for 2007-2012, in implementing Good Governance and empowering community, or as they say "Jakarta yang Nyaman dan Sejahtera untuk Semua", RSUD Koja, comes up with the following mission and vission statement:

Vision : RSUD Koja Dambaan Seluruh Masyarakat (Yearning the whole community)

Mission : Provide wholehearted, professional and affordable service

Objective : To achieve excellent service in order to comply with Jakarta healthy.

In consideration to the location of RSUD Koja is in North of Jakarta, precisely at Tanjung Priok, off the coast of the port, near the area of warehousing or industrial and surrounded by dense population with low socioeconomic status, the duties and functions of the hospital is always followed by a priority for emergency services and for poor patients. Their main task is to carry out health

efforts in an efficient and effective manners by focusing on the effort of healing process and recovery in harmony and also implementing referrals. RSUD Koja's function can be described as follow:

1. To provide medical services
2. To provide medical and non-medical support services
3. To provide nursing care services
4. To provide reference services
5. To provide learning and development
6. Administration and Financial

Health and non-health education function is including Doctors, Dentists, Specialist, Nurse, Pharmacist, community health workers, Nutrionist, Physioterapist, Medical staff, and environmental specialist. As a reference hospital in North Jakarta, RSUD Koja has establish several types of excellent medical service in order to improve the quality of health services to the public. Those services are:

1. Outpatient service includes emergency unit
2. Medical support facilites (pharmacy, laboratorium, radiology and nutrition installation)
3. Electromedical Services
4. Surgery
5. Maternity
6. Inpatient services
7. Administration and Finance

Table 3.2 Facilites for Outpatient Unit in RSUD Koja

Unit	Facilities
Outpatient	• Emergency Room : Resuscitation room, rooms for surgical and non-surgical, observation room, surgery room, radiology and laboratorium, 24 hours every day, ECG, Defibrilator • Toddler: policlinic, 24 hours every day, child care section, Perinathology • Surgery • Internist : Policlinic, Diabetes Melitus Unit, Hypertency Unit, Hepathology Unit • Maternity : 24 hours service • Dental : Tooth extraction, Odentektomy, Extirpation Mucocele, Scalling, Abses medication, Mouth surgery • EMT : Diagnostic and therapy, Audiometry examination, Cauterisation, Sinus, Tonsilektomy • Eyes : refraction examination, Tonometry and Fundoscoply • Dhermatology • Accupuncture • Neural Unit : Electro ensafalography • Medical Rehabilitation : Diatermic, Infra red Sonar, ENS (Electrical Nerve Stimulation), Ultrasound. • Anastetics : Resuscitation, anastetics for surgery • Medical Record
Laboratorium	• Routine Hematology, Blood chemical, Urine and feces, BTA Microbiology • Seerology : Pregnancy test, Hbs Ag, and Anto-Hgs Ag • Electrolit and Astrup
Radiology	• Photo Thoracs, Pyelography Intravena, Histerosalpingography • OMD, Maag and duodenum • Panoramic • C arm
Nutrition	• Providing food for inpatient customer with diet prescription from doctors • Nutrition consultancy • Training, seminars and education in regards of nutrition • Providing food for doctors and nurse • Providing food for patient
Pharmacy	• Planning health service and medicines • Medicine distribution

Source from RSUD Koja

3.6 RSUD Koja Organization Structure

We can see the organization structure and the board of directors of the hospital by looking this below figure:

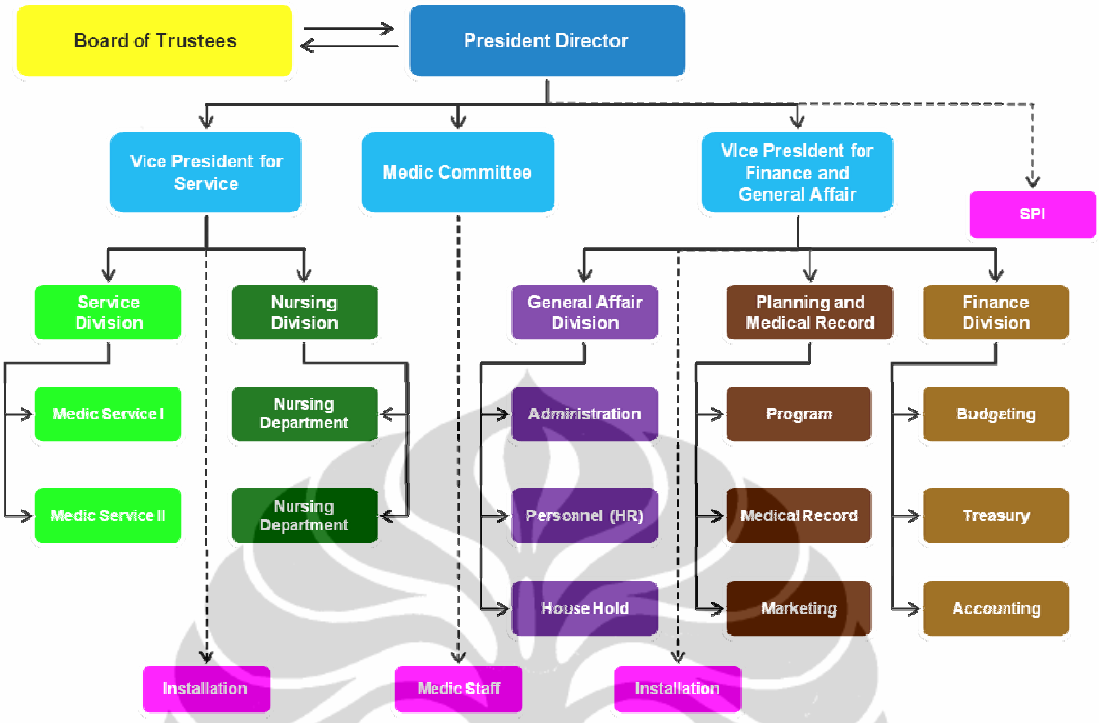

Figure 3.8 RSUD Koja Organization Structure

Source from RSUD Koja

3.7 RSUD Koja Staffing Composition

Based on September 2008 data, the staffing composition for RSUD Koja based on expertise can be seen through the table below:

Table 3.3 RSUD Koja Staffing Composition

Type	Government Official (DepKes)	Government Official (DKI)	Temporary (PTT)	Honorium (Permanent)	Honorium (Daily)	Total
Medical Staff	6	40	0	4	8	**58**
Nursing	0	118	27	40	101	**286**
Paramedics	1	23	9	32	14	**79**
Non Medic Staff	0	53	0	142	48	0
	7	**234**	**36**	**218**	**171**	

Source from RSUD Koja

Table 3.4 RSUD Koja Employment Type

Employment Type	Government Official (DepKes)	Government Official (DKI)	Temporary (PTT)	Honorium (Permanent)	Honorium (Daily)
Medical Staff					
Doctor Specialist	6	27	-	-	7
General Practioner	-	9	-	4	1
Dentist	-	4	-	-	-
Nursing					
Nurse (Bachelor)	-	5	-	1	-
Nurse (Diploma)	-	79	24	37	98
Practitioner Nurse (SPK)	-	14	2	2	-
Midwife Nurse	-	5	-	-	-
Midwife	-	15	1	-	3
Other Nursing Service	-	-	-	-	-
Treatment Paramedics					
Pharmacist	1	1	-	-	2
Pharmacy Analyst	-	-	3	-	3
Pharmacist Asistant	-	5	-	22	-
Nutrionist	-	-	-	-	-
D4 Nutrion	-	-	-	-	-
D3 Nutrion	-	2	-	2	-
D1 Nutrion	-	-	-	-	-
Physiotherapist	-	-	-	-	1
Speech Therapist	-	-	-	1	-
Radiographer	-	5	-	3	3
Dental Care Regulator	-	3	-	-	-
Electromedic Technician	-	1	-	-	1
Health Analyst (Diploma)	-	3	6	3	4
Optitient Refractionist	-	-	-	-	-
Other Medical Technician	-	3	-	1	-
Non Medic Staff	-	53	-	142	48
Total	**7**	**234**	**36**	**218**	**171**

Source from RSUD Koja

3.8 RSUD Koja Role and Participation

RSUD Koja is located where the circumstances sorrounding the community is not enviromentally sanitize. The population demograhic is in middle-low economic status where the education level is still limited due to the natura of works are workers, fishermans or low economic traders. Because people are less concerned about environmental hygiene factors, dengue fever is commonly an issue during the rainy season. In addition, with the emergence of flood disasters every year, those whose house become victimize come in large numbers to the hospital to stay over. Because the room is not available, through cooperation and coordination with related installation, the refugees are provided with tents at the hospitals parking place. Hospital functions became wider because

they have to cope with widespread flooding victims, including food preparation, and handling the health conditions.

Other activities run by RSUD Koja is through cooperation with local companies or institution to held events such as mass circumcision or other medical action operations, particularly aimed for poor communities. In addition, RSUD Koja also develop several hospital promotion activities such as creating health clubs (Asma Club, Diabetes Club, Heart Club) and working along with the communities aiming for preventive actions. Another activity is providing seminars and education about prevention and treatment of diseases, especially communicable diseases and other diseases for community with proffesionals speakers. Furthermore, the officer in RSUD Koja officially provide education about hygiene and health to patients and their families who are already allowed to go home, hoping that the patients will be healed completely and not contracting the same disease. In December 2006, RSUD Koja provide services to flood victims patient who is suffering from various diseases such as diarrhea and gastro entritis. Most of those people were unable to pay medical expenses, therefore the government issued instructions to the hospital to provide free services and conditions and classified it as as exceptional events (KLB).

3.9. RSUD Koja Agreement with Companies or Third Parties

Koja Hospital has been developing marketing function of the hospital to increased their revenue by approaching several companies that are located in the warehouse and port area of Tanjung Priok. Generally those company has entered into an agreement with PT. Jamsostek by using the products and services for work accident health insurance. As a public hospital classified as B class, RSUD Koja's facilities and infrastructures are adequate enough to serve those customers from companies. Up until December 2007, there are 31 companies hade make the agreement besides PT Jamsostek, PT. Askes or other insurance companies. Access to transportation routes of these companies are strategic enough to reach the location of RSUD Koja, the problems is only the high number container who often interfere with the traffic in office hours.

CHAPTER 4
RESEARCH MODEL

4.1 Research Scope

The objective of this research is to analze and generate a grand strategy for marketing in a not-for-profit organization who needs to balance their objective for social care while maintaining their growth and become sustainable in the future, taking a case study in RSUD Koja, a government owned public hospital. Pricing is becoming one of the important element in marketing strategy that we would like to analyze. Three questions can be raised in regards of the marketing strategy:

- Does the strategy fit the organization's situation?
- Has the strategy yielded a sustainable competitive advantage?
- Has the strategy produced good financial performance?

To answer those questions, we are using self-assessment from Peter Drucker that is essential and relevant for social sector organization. This self-assessment are to answer the following questions:

- What is our mission?

  Here we try to identify what is the current mission of RSUD Koja. What percisely are their challenges or opportunites and does the mission itself needs to be revisited.
- Who is our customer?

  To answer this question, we need to identify the primary and supporting customer for RSUD Koja and seek whether their customer will change.
- What does the customer value?

  Assess what do the primary and supporting customer of RSUD Koja valued from their organization and what knowledge do the hospital need to gain from it.
- What is our result?

  What is the service performance of RSUD Koja? Does the marketing strategy in pricing enable them to be a competitive organization without having to rely on government subsidies? How about the service performance of each of their unit?
- What is our plan?

  How can we improve and generate a grand strategy in marketing for RSUD Koja?

4.2 Research Method

Approach in collecting data for this thesis is using a qualitative method. There are two forms of data collecting forms:

- Primary data, which is collected from interview, discussions with professionals, field notes, and observations.
- Secondary data, which is collected from literatures, journals, reference books and various texts or articles

4.2.1 Data Processing for Primary Data

The primary data obtained from interview process are use to test the secondary data, therefore the interview can reinforce the information obtained from secondary data. Interviews in this research was done by asking questions to the interviewees, in this case are Management and staff of RSUD Koja. Management and staffs who were interviewed in the process of collecting data for this study were Director of Finance, Finance staffs and Marketing Staffs. The questions asked during the interview are:

- What is your organization's reason for being?
- What is the organization's current understanding of the its mission and vision?
- What significant challenges is the organization facing –changing demographics, legislation or regulations? How about the significant opportunities that are presenting themselves -partnership and collaboration, leading edge practices or approaches?
- What are the groups of customers should the organization be serving?
- What special competencies does the organization have to benefit them?
- How well does your organization provide what each of your customer consider value?
- What are your customer's long term aspirations and what is your capacity and competency to deliver on those aspirations?
- How would you define results in the future and to what extent has your organization achieved this results?
- How well is your organization using its financial resources?

4.2.2 Data Processing for Secondary Data

Literature review conducted to obtain secondary data that are useful for exploring the process of internal and external conditions, which then will be used at the input stage of a series of strategy formulation process. The literature review used in this study are:

- Organization Internal Report
  - Financial Report, which is used to determine the cost recovery rate to evaluate how far income from hospital service can cover operational cost.
  - RSUD Koja Strategic Plan, which is used to identify the business activities and performance of each unit in the hospital and determine their competitive advantage. Strategic plan is also contains the information of RSUD Koja's Vision and mission as well as their strategic actions.
  - Service rate reports, which is used to analyze their pricing tactics in marketing for each type of primary customer.
- Publication of Government institution

  In addition to obtaining data about the condition of the hospital and industry conditions, we also gather datas about the health condition in DKI Jakarta, particulary in North of Jakarta. This data was obtained from publications by government agencies, in this case the Central Statistics Agency (BPS) and Department of Health Ministry.

4.3 Strategy Analysis

Strategy analysis and choice seeks to determine alternative courses of action that could best enable the organization to achieve its mission and objectives. The organization's present strategies, objectives and mission coupled with the external and internal audit information, provide a basis for generating and evaluating feasible alternative strategies. Important of strategy-formulation techniques can be integrated into a three-stages decision making framework as shown in figure 5. For this thesis, we are only going to review all matrix in stage 1

; TOWS Matrix and Internal-External (IE) matrix from stage 2; and Grand Strategy Matrix from stage 2.

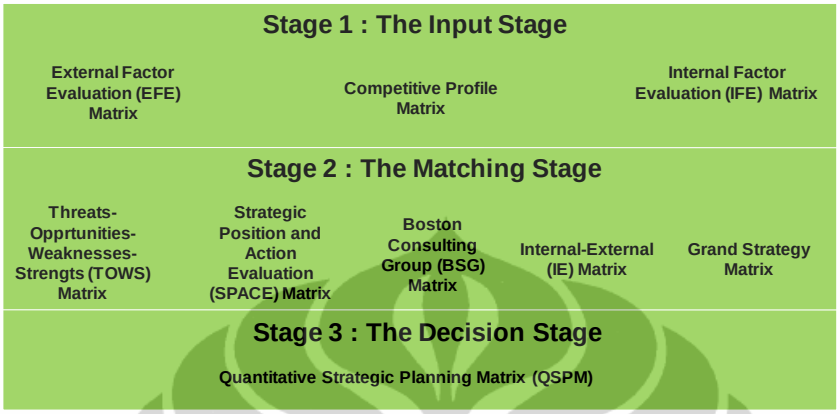

Figure 4.1 The Strategy Formulation Analytical Framework

Source from Strategic Management by Fred David (1997)

4.3.1. The Input Stage

The information derived from this stage provides basic input information for the matching and decision stage matrix on the other stages. The input tools require strategist to quantify subjectivity during early stages of the strategy-formulation process. Making small decision in the input matrices regarding the relatively importance of external and internal factors allows strategist to generate and evaluate alternatives strategies more effectively. Good intuitive judgement is always needed in determining appropriate weights and ratings.

- The External Factor Evaluation (EFE) Matrix

  EFE Allows strategist to summarize and evaluate economic, social, demography , cultural, environmental, political, governmental, legal, technological and competitive information. Regardless of the number of key opportunites and threats included in EFE Matrix, the highest possible total weighted score for an organization is 4.0 and the lowest possible total weighted is 1.0. The average total weighted score is 2.5. A total weighted score of 4 indicates that an organization is responding in an outstanding

way to existing opportunites and threats in its industry. A total score of 1.0 indicates that the organization's strategies are not capitalizing on opportunites or avoiding external threats.

- The Internal Factor Evaluation (IFE) Matrix

  IFE summarizes and evaluates the major strength and weaknesses in the functional area of business and it also provides a basis for identifying and evaluating relationship among those areas. Intuitive judments also took a major part in developing an IFE Matrix. Regardless of the number of key strength and Weaknesses included in IFE Matrix, the highest possible total weighted score for an organization is 4.0 and the lowest possible total weighted is 1.0. The average total weighted score is 2.5. Total weighted scores well below 2.5 characterize organization that are weak internally, whereas scores significantly above 2.5 indicates a strong internal position.

4.3.2. The Matching Stage

Matching Stage consist of five techniques that can be used, however only two techiques that will be used in this thesis, TOWS and IE Matrix. These tools rely upon information deived from the input stage to match external opportunities and threats with internal strenghts and weaknesses. Matching external and internal success factors in the key to effectively generating feasible alternative strategies.

- Threats-Opportunity-Weaknesses-Strength (TOWS) Matrix

  TOWS help organization to develop four type of strategies: SO, WO, ST and WT:

  a. *SO strategies* use a firm's internal strength to take advantage of external trends and events. Organization generally will pursue WO, ST and WT strategies in order to get into a situation where they can apply SO strategies. When an organization has major weaknesses, it will strive to overcome them and make them strenghts. When an organization faces major threats, it will seek to avoid them in order to concentrate on opportunites.

b. *WO Strategies* aim at improving internal weaknesses by taking advantage of external opportunities. Sometimes key external opportunites exist, but an organization has an internal weaknesses that prevent it from exploiting those opportunites.

c. *ST Strategies* use an organization's streghts to avoid or reduce the impact of external threats. This does not mean that a strong organization should always meet threats in the external environment head-on.

d. *WT Strategies* are devensive tactics directed at reducing internal weaknesses and avoiding environmental threats. An organization faced with numerous external threats and internal weaknesses may indeed be in a precarious position. Infact, such an organization may have to fight for its survival, merge, retrench, delcare bancruptcy or choose liquidation.

- Internal-External (IE) Matrix

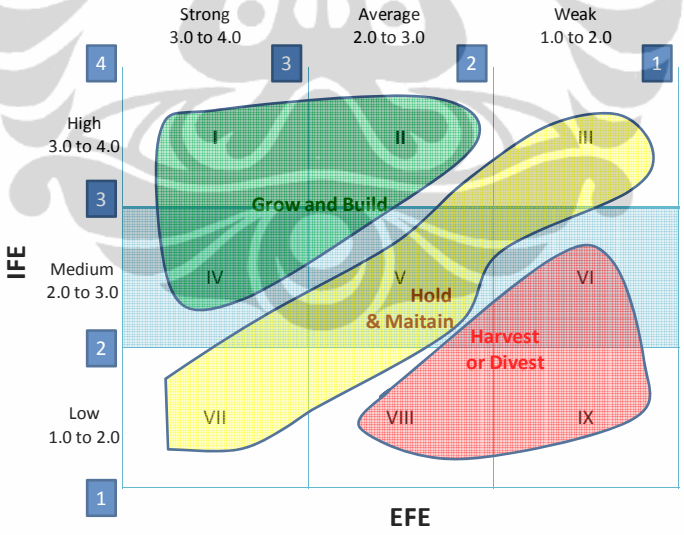

Figure 4.2 The Internal – External Matrix

Source from Strategic Management by Fred David (1997)

IE Matrix positions an organization's various divisions in a nine-cell display. IE matrix is based on two key dimension; the IFE total weighted

scores on the horizontal axis and EFE total weighted scores on the vertical axis. It can be divided into three major regions that have different strategies implications.

- Divisions that falls into cells I, II or IV can be described as *grow* and *build*. Intensive (market penetration, market development and product development) or integrative (backward integration, forward integration and horizontal integration) strategies can be most appropriate for these divisions.
- Divisions that fall into cells III, V or VII can be best managed with *hold* and *maintain* strategies; market penetration and product development are the common strategies for this type.
- Division that falls into cells VI, VIII or IX is *harvest* or *divest*. Successfull organization are able to achieve a portfolio of business positioned in or around cell I in the matrix.