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Village-Campus-Red Cross Collaboration for Voluntary Blood Donation in Cirebon

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ABSTRACT

This community service program described the implementation and immediate outputs of a one-day collaborative blood donation drive in Kertawinangun Village, Kedawung District, Cirebon, Indonesia. The activity was conducted on 3 February 2024 by the Cirebon Indonesian Red Cross, the village government, and STIE Cirebon. The program comprised logistical preparation, pre-donation information, registration, confidential clinical screening, blood collection by authorized personnel, post-donation observation, and brief participant feedback. Evaluation used descriptive process and output indicators covering participant characteristics, screening eligibility, completed donations, blood bags collected, and immediate responses. Twenty-five people registered, including 8 men and 17 women. Seventeen participants (68%) met the screening requirements and completed donation, producing 17 blood bags; 8 participants (32%) were temporarily deferred. Brief feedback indicated that some participants initially feared the procedure but reported relief and satisfaction after donation. The program demonstrated a feasible village-campus-Red Cross role-sharing model: the village mobilized participants and provided the venue, the campus team supported nonclinical operations, and the Red Cross managed screening and blood collection. Because no standardized pretest, posttest, or longitudinal follow-up was used, the program does not claim changes in knowledge or repeat-donation behavior. Future activities should include structured education evaluation, aggregate deferral records, and follow-up communication for eligible and temporarily deferred donors.

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1. Introduction

Blood transfusion services depend on the availability of blood and blood components that are safe, sufficient, and accessible when clinically required. Transfusion support is essential in *emergency* bleeding, surgery, obstetric complications, severe anemia, cancer treatment, inherited blood disorders, and other conditions. Nevertheless, blood availability remains uneven across countries and income groups. The World Health Organization reported that approximately 120.4 million blood donations are collected globally, while donation rates remain substantially lower in lower-middle- and low-income countries than in high-income countries (World Health Organization [WHO], 2026a). These disparities indicate that blood supply is not solely a clinical issue; it also depends on governance, public participation, donor recruitment, safe collection systems, and the continuity of voluntary donation programs (WHO, 2026b).

Voluntary, non-remunerated donation is a central principle of a safe and sustainable blood system. The willingness of healthy people to donate must be supported by appropriate information, convenient access, respectful treatment, and reliable clinical screening. Recruitment alone is insufficient when potential donors are uncertain about the procedure or do not return after their first experience. Evidence shows that fear is associated with attrition among first-time whole-blood donors, partly through reduced confidence and less favorable attitudes toward future donation (France et al., 2021). Donors also expect clear communication, efficient services, privacy, and explanations when they are temporarily unable to donate. Addressing donor concerns is therefore relevant not only to immediate collection but also to future recruitment and retention (Chand et al., 2023).

In Indonesia, blood services form part of the national health-service system under Government Regulation Number 28 of 2024, which implements the Health Law and replaced the former Government Regulation Number 7 of 2011 (Government of the Republic of Indonesia, 2024). Operational standards for transfusion services are further regulated through the Ministry of Health Regulation Number 91 of 2015. These standards emphasize adequate and quality-assured blood services, donor selection, donor protection, recipient protection, and the professional management of collection and screening processes (Ministry of Health of the Republic of Indonesia, 2015). Consequently, community organizations and universities may facilitate donor mobilization and venue management, but eligibility assessment, blood collection, and clinical decisions must remain under authorized blood-service personnel.

Community-based blood drives can reduce practical access barriers by bringing an authorized service closer to residents, students, and employees. Previous Indonesian community service reports demonstrate that collaboration with the Indonesian Red Cross (Palang Merah Indonesia [PMI]) can mobilize potential donors and produce immediate blood-collection outputs. Pongantung et al. (2022), for example, reported 30 registrants in a youth community activity, of whom 12 completed donation after screening. Sutrisna et al. (2023) combined health education with facilitated blood donation and emphasized the importance of information in supporting donor confidence. Veronica et al. (2024) described a community activity that integrated counseling and donation in a residential setting. These programs show the practical value of local partnerships; however, community service manuscripts frequently need clearer distinctions among activities, outputs, measurable outcomes, and long-term impacts. A blood drive may successfully produce blood bags without automatically demonstrating increased knowledge, awareness, or repeat-donation behavior unless those outcomes are measured with appropriate instruments and follow-up.

Kertawinangun Village is located in Kedawung District, Cirebon Regency, West Java. Initial coordination among village representatives, the Cirebon PMI team, and the STIE Cirebon community service team identified an opportunity to provide a locally accessible donation session and mobilize residents together with students and lecturers. The source program did not include a formal baseline

knowledge survey or a documented numerical estimate of local blood shortage. Therefore, the priority problem was defined operationally: potential donors needed a safe, convenient, and professionally managed opportunity to participate, while the partners needed a clear division of clinical and nonclinical responsibilities. This definition avoided unsupported claims about community awareness and aligned the program objective with data that could actually be collected during a one-day activity.

The added value of the program lies in its three-party collaboration model. The village government supported local mobilization and venue readiness; the campus team organized volunteers and assisted the participant flow; and the PMI team controlled donor information, clinical screening, collection, and post-donation safety. This model is modest rather than technologically novel, but it is relevant to community service because it demonstrates how institutions with different resources can share responsibilities without transferring medical tasks to unqualified volunteers. The article also reports deferral as a safety outcome rather than treating it as program failure. Temporary deferral protects both donors and recipients, and clear information about the reason and possible future eligibility is important for maintaining donor willingness. A field randomized trial found that additional information following deferral increased subsequent donor return, supporting the need for respectful, specific communication to temporarily deferred volunteers (Spekman et al., 2023).

Accordingly, this community service program aimed to describe the implementation of a collaborative voluntary blood donation drive in Kertawinangun Village; report participant characteristics, screening eligibility, and blood-collection outputs; summarize immediate participant feedback; and identify practical improvements for recurring village-based donation activities. The expected immediate outputs were the completion of a safe donation workflow, active participation by the three partner groups, and the collection of blood from eligible participants. Changes in knowledge, attitudes, or repeat-donation behavior were not specified as evaluated outcomes because standardized baseline, post-intervention, and follow-up measurements were unavailable.

2. Methods

This activity used a participatory community service design with descriptive process and output evaluation. It was conducted on Saturday, 3 February 2024, beginning at 09:00 at the Kertawinangun Village Hall, Kedawung District, Cirebon Regency, Indonesia. The partner institutions were the Kertawinangun Village Government, the Cirebon PMI blood service team, and STIE Cirebon. The target group consisted of village residents and members of the campus community who voluntarily attended the open donation activity. Recruitment was coordinated through the village and campus networks. Because participation was open and attendance was voluntary, the program used a convenience participant group rather than probability sampling.

The needs-assessment process was a rapid participatory assessment conducted through coordination discussions among the partner teams before implementation. The discussions identified three practical requirements: an accessible venue for local participants, professional donor screening and blood collection, and volunteers to manage registration flow and nonclinical logistics. No formal questionnaire, focus group transcript, or local blood-stock dataset was produced during the initial assessment. The priority intervention was therefore a professionally supervised community blood drive rather than an educational experiment. This limitation was incorporated into the evaluation design so that the article would report verifiable activities and outputs without inferring unmeasured changes.

The intervention was organized into preparation, implementation, and immediate evaluation. During preparation, the partners established the organizing team, agreed on the date and venue, discussed the activity sequence, prepared the room and supporting equipment, and divided responsibilities. The village team supported venue access, local coordination, and participant mobilization. The STIE Cirebon team assisted communication, participant flow, nonclinical registration support, waiting-area organization, and documentation. PMI personnel were responsible for all clinical procedures, including verification of donor information, medical interview, physical and

laboratory screening as required, eligibility decisions, phlebotomy, blood-bag handling, and post-donation observation.

Implementation began with opening remarks and brief pre-donation information from the PMI team. The information covered the social purpose of voluntary donation, the general donation process, the importance of truthful health information, donor and recipient safety, and the possibility of temporary deferral. Participants then completed the applicable donor registration documentation and proceeded through the PMI screening process. Screening followed the blood-service procedure applicable at the time of the activity and considered age, body weight, general health, medical history, blood pressure, pulse, hemoglobin, donation interval, and other temporary or permanent eligibility factors. The Ministry of Health Regulation Number 91 of 2015 was used as the principal national reference for transfusion-service standards (Ministry of Health of the Republic of Indonesia, 2015). Individual eligibility decisions were made exclusively by PMI personnel and were not influenced by the village or university teams.

Eligible participants proceeded to blood collection and post-donation observation. Participants who did not meet the requirements were privately informed by the clinical team and did not undergo collection. To protect confidentiality, the community service team retained only aggregate information for publication. The available source data identified blood pressure outside the applicable range and temporary health conditions among the reasons for deferral, but the number in each category was not documented in a form suitable for publication. Therefore, the results report only the total deferred count and do not reconstruct or estimate a category distribution.

Program evaluation was aligned with the stated objectives. Process indicators included completion of the planned stages, participation of all partner groups, and implementation of clinical procedures by authorized personnel. Output indicators included the number of registered participants, sex distribution, number and proportion eligible to donate, number and proportion temporarily deferred, number of completed donations, and number of blood bags collected. Immediate participant experience was explored through brief informal post-donation conversations about feelings before and after donation. These conversations were not conducted using a standardized interview guide and were not audio-recorded; therefore, they were summarized only as contextual feedback rather than analyzed as formal qualitative data.

Quantitative data were analyzed descriptively using frequencies and percentages. The eligibility rate was calculated as the number of participants who completed donation divided by all registered participants, multiplied by 100. The deferral rate was calculated using the same denominator. No inferential statistical test was performed because the activity involved a small, nonrandom participant group and did not compare intervention conditions or repeated measurements. The program did not collect a standardized pretest-posttest, a validated satisfaction scale, blood-type distribution, first-time versus repeat-donor status, or longitudinal return data.

Participation in donation was voluntary, and clinical screening was confidentially managed by PMI personnel. This article reports only aggregate data and contains no participant names, individual screening results, contact information, or identifiable health records. Nonclinical volunteers did not perform medical assessment or blood collection. For future activities, the recommended sustainability strategy is to schedule periodic drives with PMI, provide pre-event eligibility information, establish a consent-based reminder mechanism under appropriate data governance, and give temporarily deferred participants clear information about the reason and possible timing of a future donation attempt.

Table 1. Program Stages, Partner Roles, and Evaluation Indicators.

Stage	Principal Activities	Responsible Partner(s)	Recorded Indicator
Preparation	Coordination, scheduling, venue preparation, role allocation, participant	Village government, STIE Cirebon, PMI	Team established; venue and workflow prepared

Stage	Principal Activities	Responsible Partner(s)	Recorded Indicator
	mobilization		
Information	Brief explanation of donation purpose, process, safety, and possible deferral	PMI, supported by organizing team	Information session delivered
Registration and screening	Registration, health interview, physical/laboratory screening, eligibility decision	PMI	Number registered, eligible, and deferred
Blood collection	Collection, blood-bag handling, donor observation	PMI	Completed donations and blood bags
Immediate evaluation	Brief post-donation feedback and organizing-team reflection	PMI, village, and campus teams	Contextual participant responses and implementation notes

Note. PMI = Palang Merah Indonesia (Indonesian Red Cross). Clinical activities and eligibility decisions were performed only by PMI personnel.

3. Results and Discussion

3.1 Program Implementation and Partner Participation

The activity was implemented as scheduled in the Kertawinangun Village Hall. The venue enabled the program to combine a familiar community setting with a clinically controlled donation workflow. The three partner groups were present and performed complementary functions. The village team facilitated local access and coordination, the STIE Cirebon team supported nonclinical operations, and the PMI team delivered information, screened potential donors, collected blood, and monitored participants after donation. All planned stages—preparation, information, registration, screening, collection, and immediate evaluation—were completed during the one-day program.

The division of responsibilities was an important implementation result. Community service activities involving health procedures can become unsafe or ethically unclear when volunteer enthusiasm is not matched with professional boundaries. In this program, clinical authority remained with PMI, while the village and campus teams concentrated on mobilization and service flow. This arrangement is consistent with the principle that blood collection should be undertaken within a quality-assured transfusion service and under established donor-selection standards (Ministry of Health of the Republic of Indonesia, 2015; WHO, 2026b). It also provides a replicable arrangement for other villages or campuses that have community networks and venues but do not have transfusion-service capacity.

The program's immediate educational component consisted of an oral explanation before screening. This was useful for procedural orientation but should not be interpreted as evidence of increased knowledge. Sutrisna et al. (2023) reported improved knowledge in an education-focused community program, but such a conclusion requires an instrument and comparison of participant scores. The Kertawinangun program did not administer those measurements. Its educational output was therefore limited to the delivery of pre-donation information and the opportunity for participants to ask questions during the service process.

The collaboration can be understood as a service pathway rather than merely a division of tasks. The village government provided social access and legitimacy, the campus team translated the event plan into participant flow and logistical support, and PMI supplied the regulated clinical capability. Each function depended on the others: a clinically competent team without local mobilization might reach too few potential donors, while strong mobilization without professional screening would be unsafe. The value of the arrangement therefore lies in complementarity and boundary clarity. This is especially important in community health programs, where visible volunteer participation may obscure who is professionally accountable for medical decisions. In the present program, the role boundary was

explicit enough to protect the donor pathway from registration to post-donation observation and to prevent students or village volunteers from undertaking activities outside their competence.

The use of the village hall also had an implementation implication. A locally familiar venue may reduce transport and access barriers, but it must still be organized to support privacy, orderly waiting, clinical screening, blood collection, and observation after donation. The source report documented completion of the workflow but did not provide time-motion data, waiting-time measurements, room-layout assessment, or a structured service-quality survey. Consequently, convenience and comfort cannot be quantified. A future program could record arrival time, screening start, collection completion, and participant exit, alongside a short checklist on privacy, clarity of directions, cleanliness, and staff communication. These measures would allow the partnership to improve operational quality rather than evaluating success only from the number of blood bags collected.

3.2 Participant Characteristics and Screening Outcomes

A total of 25 potential donors registered for the activity. Eight participants were men and 17 were women, representing 32% and 68% of registrants, respectively. Seventeen participants met the screening requirements and completed blood donation, while eight were temporarily deferred. The resulting eligibility rate was 68%, and the deferral rate was 32%. The available aggregate dataset did not permit cross-tabulation of eligibility by sex, age, donor history, hemoglobin level, or specific deferral reason; consequently, no association between participant characteristics and eligibility was tested.

Temporary deferral should be interpreted as a safety decision rather than a negative judgment of the participant or a failure of the activity. Screening is intended to prevent donation when it may adversely affect the donor or create a risk for the recipient. The source record indicated that blood pressure outside the applicable range and temporary health conditions contributed to deferrals, but the reasons were not numerically disaggregated. Publishing an assumed breakdown would be methodologically inappropriate. Future programs should request an anonymized aggregate recap from PMI, with categories such as hemoglobin, blood pressure, donation interval, medication, recent illness, or other temporary conditions, without disclosing individual health information.

The 68% eligibility rate illustrates why organizers should recruit more potential participants than the desired number of blood bags. Screening naturally reduces the number who can donate on a particular day. In another community service program, Pongantung et al. (2022) reported that 12 of 30 registrants completed donation, whereas Veronica et al. (2024) reported 68 eligible blood bags from 72 participants. The wide variation across activities may reflect differences in participant age, prior donor experience, pre-event information, health status, recruitment setting, and local screening records. Direct comparisons should therefore be descriptive rather than treated as evidence that one program was clinically superior.

The predominance of women among registrants is a descriptive characteristic of this particular activity and should not be generalized to the village population. The absence of age, occupation, donor history, and sex-specific eligibility data prevents an explanation of why participation differed by sex or whether the composition affected the deferral rate. Reporting these limits is preferable to constructing an unsupported narrative about willingness or health eligibility. For future events, organizers should agree with PMI on a minimal anonymous dataset before implementation. A practical dataset could include age group, sex, first-time or repeat-donor status, eligibility result, broad anonymous reason for deferral, and completion status. Such data would improve recruitment planning while preserving confidentiality and keeping individual clinical records under PMI control.

Deferral management should also be incorporated into the participant pathway. Eight people invested time in attending but did not complete donation. Treating them only as unsuccessful registrants would ignore their willingness to contribute and could weaken future engagement. The appropriate response is not to pressure them to donate but to provide accurate, individualized clinical

information and, when the reason is temporary, a clear indication of whether and when another attempt may be appropriate. Evidence that additional post-deferral information can increase subsequent return supports this retention-oriented approach (Spekman et al., 2023). At the program level, an anonymous follow-up indicator could record how many deferred participants received an explanation and how many returned at a later eligible session, provided contact and follow-up are based on consent.

Table 2. Participant Registration and Blood Donation Outcomes.

Indicator	Number	Percentage (%)
Registered participants	25	100.0
Men	8	32.0
Women	17	68.0
Eligible and completed donation	17	68.0
Temporarily deferred	8	32.0
Blood bags collected	17	—

Note. Percentages use all 25 registered participants as the denominator. Sex-specific eligibility and detailed deferral categories were not available.

3.3 Blood Collection Output and Achievement of Program Indicators

The principal tangible output was the collection of 17 blood bags from 17 eligible participants. Each successful donation therefore generated one blood bag, and the collection yield was 0.68 blood bag per registered participant. The manuscript source did not document a numerical collection target agreed upon before the event. For that reason, this article does not label the result as exceeding or falling short of a target. Instead, it reports the actual output and the conversion from registration to completed donation.

At the process level, the program achieved the intended collaboration, completed the planned workflow, and maintained the separation between clinical and nonclinical roles. At the output level, it mobilized 25 potential donors and produced 17 blood bags. At the outcome level, evidence was limited. The activity may have provided participants with information and a positive opportunity to contribute, but changes in knowledge, attitude, intention, or behavior were not measured. At the impact level, no claim can be made regarding long-term blood availability or repeat donation because the study did not track blood utilization or donor return.

This distinction is important for the credibility of community service reporting. Blood collection itself is a valuable immediate output, but one-day collection does not establish a sustainable donor community. Sustainable contribution requires repeated sessions, donor retention, and follow-up of both successful and deferred participants. Chand et al. (2023) emphasized that donor recruitment and retention benefit from addressing practical concerns and suggestions. Therefore, the next cycle should combine accessible collection with structured communication before, during, and after the event.

Future planning would be stronger if targets were set at several levels before implementation. A process target might require all three partners to complete agreed responsibilities; a recruitment target might specify the number of registrants needed; an output target might specify a desired range of completed donations; and an evaluation target might require a defined response rate to a participant questionnaire. Because screening creates an unavoidable difference between registration and collection, the recruitment target should be higher than the desired number of blood bags. The 68% conversion observed here can inform local planning, but it should not be treated as a stable prediction because the rate may change with participant characteristics, health conditions, recruitment methods, and timing. Targets should therefore be reviewed after each cycle and adjusted using accumulated local data.

The 17 blood bags represent a concrete service output, but the public value of the program also includes the safe organization of donation and the establishment of a workable partnership. These dimensions should be reported separately. A higher number of registrants would not necessarily indicate better performance if the service became overcrowded, privacy was compromised, or clinical staff were overextended. Conversely, a modest collection can still be operationally meaningful when it strengthens procedures and prepares partners for recurring activities. Balanced evaluation should therefore combine volume indicators with process quality, donor experience, and continuity. This approach is consistent with donor-retention literature emphasizing communication, responsiveness to concerns, and reliable service experience rather than recruitment numbers alone (Chand et al., 2023; France et al., 2021).

Table 3. Achievement of Process, Output, Outcome, and Impact Indicators.

Level	Indicator	Observed Result	Interpretation
Process	Planned stages and partner participation	All stages completed; village, campus, and PMI teams participated	Achieved
Output	Potential donors mobilized	25 registrants	Achieved; no numerical target documented
Output	Completed donations and blood bags	17 donations and 17 blood bags	Achieved as an actual collection output
Outcome	Change in knowledge, attitude, or intention	Not measured with a standardized instrument	No causal or improvement claim
Impact	Repeat donation and contribution to long-term supply	No longitudinal follow-up	Not evaluated

Note. The table distinguishes verified program results from outcomes that were not measured.

3.4 Immediate Participant Feedback

Brief post-donation conversations indicated that some participants initially felt afraid when blood was about to be collected. After completing the procedure, participants generally reported that their concern had decreased and expressed satisfaction that they had contributed to people who need transfusion. These statements are consistent with the source activity report, but they were not obtained through a standardized interview protocol. They should therefore be interpreted as contextual observations rather than prevalence estimates or formal evidence of attitude change.

Fear deserves attention because it may influence both the first donation experience and future retention. France et al. (2021) found that fear was associated with attrition among first-time whole-blood donors, with donor confidence and attitude functioning as potential explanatory mechanisms. A well-managed community drive can respond by explaining each step, avoiding exaggerated health claims, providing privacy, maintaining an orderly waiting process, and ensuring calm interaction with trained personnel. Future activities could add a brief anonymous questionnaire before and after donation that measures procedural understanding, anxiety, satisfaction, and intention to return.

Participants who were deferred also require respectful communication. A person who attends with the intention to help may feel disappointed or believe that deferral is permanent. Spekman et al. (2023) demonstrated in a field randomized trial that additional information after deferral increased donor return. Although the Kertawinangun program did not evaluate return behavior, this evidence supports a practical improvement: each deferred participant should receive an understandable explanation, the temporary or permanent nature of the decision, the recommended next step, and—when appropriate—the time at which another donation attempt may be considered.

A standardized feedback instrument does not need to be lengthy. A brief anonymous form could ask whether the participant understood the procedure, felt that privacy was protected, received clear

information, experienced manageable anxiety, was satisfied with the service flow, and intended to donate again when eligible. Items could use a five-point response scale and include one open question for suggestions. For temporarily deferred participants, a separate item should assess whether the explanation and next steps were understood. Administering the form after the clinical decision, without recording names or sensitive diagnoses, would produce more defensible evidence than informal conversation. Repeating the same core items across donation cycles would also allow the partners to identify service improvements or recurring problems.

3.5 Sustainability, Replicability, and Limitations

The collaboration model is feasible for replication because it relies on resources commonly available to village and campus partners: a suitable venue, local communication networks, volunteers for nonclinical flow, and an authorized mobile blood-service team. Replication should begin with an explicit written role matrix and a numerical recruitment plan that anticipates temporary deferral. Pre-event information should clarify general eligibility, preparation before donation, the possibility of deferral, and the importance of honest health disclosure. The clinical team should retain full authority over screening, collection, post-donation care, and confidential data.

Sustainability requires moving beyond a single ceremonial activity. The village and campus partners can propose a periodic schedule with PMI, but reminders and donor contact should be handled through consent-based procedures and appropriate personal-data governance. A future evaluation should record first-time and repeat-donor status, anonymous deferral categories, education scores, satisfaction, and return within the next eligible period. Temporarily deferred participants should be included in the follow-up strategy rather than being excluded from future mobilization. These steps can transform an isolated drive into a developing local donor network while maintaining donor safety.

Several limitations affect the interpretation of this program. First, the participant group was small, self-selected, and drawn from a single one-day activity. Second, the program did not conduct a formal baseline needs survey or use local blood-stock data. Third, no standardized pretest, posttest, satisfaction scale, or longitudinal follow-up was administered. Fourth, the dataset did not contain age distribution, first-time versus repeat-donor status, blood group, hemoglobin values, detailed anonymous deferral categories, or sex-specific eligibility. Fifth, immediate feedback was informal and cannot be treated as a formal qualitative study. Sixth, the manuscript did not include a standardized record of adverse donor reactions; therefore, safety conclusions are limited to the reported completion of the activity and cannot establish an adverse-event rate. These limitations do not negate the 17 collected blood bags, but they require restrained conclusions and provide a clear agenda for improving the next program cycle.

A practical sustainability cycle can be organized as assessment, planning, implementation, review, and follow-up. Before each event, the partners should review previous registration, eligibility, deferral, waiting-time, and feedback data; agree on roles and recruitment targets; and confirm the authorized clinical team's capacity. During implementation, standardized process records should be completed without collecting unnecessary personal data. After the activity, the partners should review outputs and service problems, communicate appropriately with eligible and deferred participants, and set a provisional date for the next session. This cyclical model is more sustainable than treating donor drives as isolated ceremonial events because it converts each activity into evidence for the next. Nevertheless, continuity depends on PMI capacity, partner commitment, consent-based communication, and compliance with transfusion-service and personal-data requirements.

4. Conclusions

The collaborative blood donation drive in Kertawinangun Village successfully implemented a one-day workflow involving the village government, STIE Cirebon, and the Cirebon PMI team. Twenty-five potential donors registered; 17 participants (68%) met the screening requirements and completed

donation, producing 17 blood bags, while 8 participants (32%) were temporarily deferred for safety reasons. The principal contribution of the program was a practical division of responsibilities in which community and campus partners supported mobilization and nonclinical operations while PMI retained control of screening and blood collection. The activity cannot be claimed to have increased knowledge, awareness, or repeat-donation behavior because those outcomes were not measured. A stronger recurring program should combine periodic donation sessions with pre-donation eligibility information, standardized education and satisfaction evaluation, anonymized aggregate deferral reporting, and consent-based follow-up for successful and temporarily deferred donors.

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6. Authors Note

The authors declare that there is no conflict of interest regarding the publication of this article. The manuscript reports aggregate program data and does not disclose participants' identities or individual health information. The authors confirm that the manuscript is an original work and has not been published elsewhere.

7. References

Chand, S., Amita, R., & Gupta, D. (2023). Addressing concerns and suggestions of blood donors: An assured way for donor motivation, recruitment, and retention. *Asian Journal of Transfusion Science, 17*(1), 103–107. https://doi.org/10.4103/ajts.ajts_154_21

France, C. R., France, J. L., Himawan, L. K., Duffy, L., Kessler, D. A., Rebosa, M., Rehmani, S., Frye, V., & Shaz, B. H. (2021). Fear is associated with attrition of first-time whole blood donors: A longitudinal examination of donor confidence and attitude as potential mediators. *Transfusion, 61*(12), 3372–3380. https://doi.org/10.1111/trf.16671

Government of the Republic of Indonesia. (2024). *Government Regulation of the Republic of Indonesia Number 28 of 2024 concerning the implementation of Law Number 17 of 2023 on Health*. https://peraturan.bpk.go.id/Details/294077/pp-no-28-tahun-2024

Ministry of Health of the Republic of Indonesia. (2015). *Regulation of the Minister of Health of the Republic of Indonesia Number 91 of 2015 concerning blood transfusion service standards*. https://peraturan.bpk.go.id/Details/116661/permenkes-no-91-tahun-2015

Pongantung, H. Y., Toreh, P. M., Suparlan, M., Tuwohingide, Y., & Lengkong, G. (2022). Donor darah komunitas remaja dengan tema “Menjadi Saudara.” *Jurnal Pengabdian Kepada Masyarakat MAPALUS, 1*(1), 26–34. https://e-journal.stikesgunungmaria.ac.id/index.php/jpmm/article/view/9

Spekman, M. L. C., van Tilburg, T. G., & Merz, E.-M. (2023). Providing extra information increases blood donor return after deferral while offering an alternative good deed does not: Results from a field randomized controlled trial. *Nonprofit and Voluntary Sector Quarterly, 52*(3), 671–696. https://doi.org/10.1177/08997640221106466

Sutrisna, M., Hasymi, Y., Susanti, I., Utama, T. A., & Wati, M. (2023). Fasilitator dan pendidikan kesehatan tentang manfaat donor darah “Sehat dan Selamatkan Jiwa.” *Community Development Journal: Jurnal Pengabdian Masyarakat, 4*(5), 9802–9806. https://doi.org/10.31004/cdj.v4i5.20222

Veronica, R., Agustina, Elwindra, Prihatini, F., Vestabilivy, E., Herlina, Umar, A. F., Fatkhurrohman, M., Nurmaisyah, I., & Suratman. (2024). Kegiatan donor darah sebagai salah satu cara membantu

meningkatkan kesehatan diri dan selamatkan nyawa sesama. *Health Care: Journal of Community Service, 2*(1), 116–125. https://doi.org/10.62354/healthcare.v2i1.21

World Health Organization. (2026a). *Blood safety and availability*. https://www.who.int/news-room/fact-sheets/detail/blood-safety-and-availability

World Health Organization. (2026b). *Global status report on blood safety and availability 2025*. https://www.who.int/publications/i/item/9789240121546