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Capability of the Bureau of Jail Management and Penology Approaches on Covid-19 Towards Policy Framework for Prevention and Control of Transmission

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ABSTRACT

The study assessed the capability of the Las Piñas City Jail Male Dormitory in implementing COVID-19 prevention and control measures and developed a policy framework to strengthen institutional preparedness and response. Specifically, it examined the profile of implementing personnel (job assignment and level of knowledge of COVID-19 prevention and control), the capability level of prevention and control approaches as expected and as practiced, the moderating effect of job assignment on prevention and control indicators, and the overall extent of capability attained. A descriptive-correlational design was employed using a total-enumeration census of 64 Bureau of Jail Management and Penology (BJMP) personnel assigned to the Las Piñas City Jail Male Dormitory, consisting of 50 personnel on lockdown and 14 response team members. A researcher-developed Response Capability Questionnaire covering three prevention sub-areas and five control sub-areas was used, with content validity established through a three-member expert panel and reliability confirmed through Cronbach's alpha on a pilot sample of five non-sample respondents. Paired-samples t-tests and one-way ANOVA were used for data analysis. Overall, COVID-19 prevention and control approaches were rated at a very high extent, both as expected and as practiced. However, statistically significant differences were found across most individual prevention and control indicators, indicating specific gaps between policy expectations and actual implementation. Job assignment did not significantly moderate most prevention and control indicators, except for the utilization of the "Ligtas" COVID-19 center. Despite these implementation gaps, the findings demonstrate a strong overall institutional capability in responding to COVID-19. A Policy Framework for the Prevention and Control of Transmission is proposed to sustain existing strengths, address identified implementation gaps, and enhance the preparedness and response capacity of BJMP facilities during future public health emergencies.

INTRODUCTION

The COVID-19 pandemic exposed with brutal clarity what public health scholars had long warned that correctional institutions characterized by overcrowding, poor ventilation, and communal living function as amplifiers rather than containers of infectious disease (Esposito *et al.*, 2022). Detention facilities house more than 10 million people worldwide, most under conditions where physical distancing is structurally impossible and where a single introduction of the virus can trigger explosive, facility-wide transmission within days (Esposito *et al.*, 2022). In the United States, Reinhart and Chen (2021) demonstrated that carceral facilities functioned as engines of community spread, with incarceration rates predicting COVID-19 case growth even in surrounding counties, evidence that jail-based outbreaks are never truly contained within jail walls. Rubin (2020) similarly that the same features which make prisons and jails effective instruments of confinement such as density, restricted airflow, shared sanitation which make them uniquely resistant to standard infection-control guidance. The Philippines entered this crisis from a position of acute vulnerability. Even before the pandemic, the country's jails held the unenviable distinction of the highest occupancy rate in the world, with the Bureau

of Jail Management and Penology (BJMP) reporting congestion of 534% across its facilities as COVID-19 began to spread in March 2020 (International Committee of the Red Cross [ICRC], 2020). Recognizing that jails with a documented history of tuberculosis outbreaks were now at heightened risk for SARS-CoV-2, the ICRC partnered with the BJMP and the Bureau of Corrections to establish isolation and quarantine capacity across Metro Manila, Calabarzon, and Central Luzon, ultimately supporting eight COVID-19 isolation centers with a combined capacity of 1,130 beds (ICRC, 2020). Cahapay (2020) documented the Philippine government's broader policy response for persons deprived of liberty (PDL), noting that national directives on decongestion, health screening, and restricted visitation were issued rapidly but implemented unevenly across facilities with vastly different resources and physical layouts, a gap between policy and practice that later studies would continue to surface.

That gap has persisted well past the pandemic's acute phase. A 2024 assessment of Manila City Jail found that while the BJMP had rigorously enforced protocols such as mandatory mask-wearing, temperature checks, and sanitization, the psychological, physical, and family-related toll on both PDL and jail officers remained

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substantial, suggesting that procedural compliance alone did not fully safeguard institutional wellbeing (Carmen, 2024). At the policy level, the United Nations Office on Drugs and Crime (UNODC, 2022) convened the Department of Justice, BJMP, and Bureau of Corrections in 2022 specifically to translate pandemic-era lessons into a harmonized framework for infection prevention and control across the Philippine correctional system. This call is an acknowledgment, at the national level, that the ad hoc measures adopted during the emergency needed to be codified into durable policy rather than treated as a closed chapter.

International experience reinforces the urgency of that codification. Esposito *et al.*'s (2022) systematic review of prison-based prevention strategies found wide variation in how countries implemented entry screening, quarantine, and visitor protocols, and proposed a standardized model including mandatory temperature checks and health questionnaires at the point of entry precisely because no consistent global protocol had emerged organically. More recent outbreak investigations illustrate why standardization matters. A 2022 outbreak in a South Korean high-rise detention center housing nearly 2,000 inmates showed that although density and shared ventilation drove rapid initial spread, layered interventions such as physical distancing, decarceration, movement restrictions, and mass testing ultimately slowed transmission despite requiring substantial resources (Song *et al.*, 2025). A mixed-methods systematic review of the global health impacts of incarceration during COVID-19 further found that the consequences of poorly controlled outbreaks extended beyond physical illness to significant psychological and social harm among incarcerated populations worldwide (Kim *et al.*, 2022). Taken together, this body of work makes clear that effective jail-level pandemic response requires more than the presence of guidelines; it requires institutional capability on the knowledge, resources, and consistent execution to translate policy into practice under real operational constraints.

It is precisely this capability that remains empirically underexamined at the facility level in the Philippines. National policy statements and cross-jail assessments describe what the BJMP was directed to do. Far less is known about the extent to which frontline personnel in a single, densely congested facility actually possessed the knowledge and operational capacity to execute prevention and control measures as designed. The Las Piñas City Jail Male Dormitory offers a critical case for this inquiry. As one of the National Capital Region facilities operating under the same congestion pressures documented nationally (ICRC, 2020), and staffed by personnel directly responsible for implementing lockdown, testing, and isolation protocols, it provides a vantage point from which to assess not merely whether policies existed, but whether the institution was truly capable of executing them and what a sustainable policy framework, grounded

in that evidence, should look like going forward.

Hence, this study was designed to determine the capability level of COVID-19 prevention and control approaches at Las Piñas City Jail Male Dormitory, with the aim of informing a policy framework for the Bureau of Jail Management and Penology. This study seeks to move the national conversation from broad directives toward the operational specificity the BJMP will need for the next public health emergency.

MATERIALS AND METHODS

Research Design

This study employed a descriptive-correlational research design. The descriptive component was used to characterize the profile of respondents and the extent to which COVID-19 prevention and control approaches were expected and actually practiced, while the correlational component tested the statistical relationship between prevention, control, and overall capability, as well as the moderating effect of respondent profile variables. This design was selected because the study did not manipulate any variable or assign respondents to conditions; rather, it measured naturally occurring perceptions of an already-implemented set of institutional protocols at a single point in time (Creswell & Creswell, 2018). A single-group, expected-versus-practiced comparison was used in place of an experimental or quasi-experimental design because random assignment or the withholding of pandemic-control protocols from a comparison group would have been operationally infeasible and ethically inappropriate in an active custodial setting during a public health emergency.

Population, Sampling and Sampling Procedures

The respondents of the study were the Sixty-Four (64) personnel of Las Piñas City Jail Male Dormitory comprising 50 Personnel on Lockdown and 14 Response Team members.

Because the total eligible personnel complement of the Las Piñas City Jail Male Dormitory during the study period consisted of only 64 uniformed personnel, a total enumeration (census) approach was used rather than a probability sampling procedure. All 64 personnel on lockdown and response team members were invited to participate, and all 64 completed the survey (100% response rate). Total enumeration was considered appropriate given the small and finite size of the accessible population, and it removes sampling error as a source of bias in the descriptive statistics.

Inclusion and Exclusion Criteria.

Personnel were eligible for inclusion if they (a) held an active duty assignment at the Las Piñas City Jail Male Dormitory as either Personnel on Lockdown or Response Team Member at the time of data collection, (b) had at least one month of continuous service under the facility's COVID-19 protocols, and (c) provided

informed consent to participate. Personnel who were on extended leave, hospitalized, or unavailable for the full duration of the data collection window were excluded, as were incomplete survey responses (defined as more than 10% missing items), which were removed prior to analysis.

Research Instrument

The following instruments were used in this study: (a) a Profile Checklist covering duty assignment and level of knowledge of COVID-19, and (b) a Response Capability Questionnaire covering prevention and control indicators, both described in full below.

Both instruments were researcher-developed based on the Interim Guidelines on the Management of Persons Deprived of Liberty and personnel issued by the BJMP and the Inter-Agency Task Force for the Management of Emerging Infectious Diseases. Item content was drawn directly from these operational protocols so that each survey item corresponded to a specific, named prevention or control measure. Prior to pilot administration, the draft instrument was submitted to a panel of three content experts; a BJMP jail health officer, a public health nursing specialist, and a research methodologist who independently rated each item for relevance and clarity; items were retained, revised, or dropped based on this panel's consolidated feedback.

Part 1 : Profile Checklist. A checklist of duty details answered by respondents and the level of knowledge of COVID-19 prevention and control of respondents.

Part 2 : Response Capability Questionnaire. A researcher-made questionnaire that consists of prevention and control. Prevention has 3 sub-areas with 2 items each and control has 5 sub-areas with 2 items each.

The items for evaluation used a Five-Point Likert Scale as follows;

5 As expected/practiced to a very high extent 4.50 – 5.00
4 As expected/practiced to a high extent 3.50 – 4.49
3 As expected/practiced to some extent 2.50 – 3.49
2 As expected/practiced to a low extent 1.50 – 2.49
1 As expected/practiced to a very low extent 1.00 – 1.49
Means that are at least 3.50 are considered strengths; means that are below 3.50 are considered as weaknesses.

Table 1: Rating Scale

Scale	Range	Descriptive Level
5	4.50 – 5.00	Very High Extent (VHE)
4	3.50 – 4.49	High Extent (HE)
3	2.50 – 3.49	Some Extent (SE)
2	1.50 – 2.49	Low Extent (LE)
1	1.00 – 1.49	Very Low Extent (VLE)

Data Collection Procedure

Data were collected over a four-week period from March 1, 2021 to March 28, 2021 using a self-administered online questionnaire distributed through a secure survey platform. All 64 eligible personnel accessed the

Validity Test

To test the validity of the instrument, the responses of the five (5) non-sample respondents were tested for significance using a one-sample t-test. If the test was not significant, the questionnaire was considered valid. If the test was significant, the items with significant tests were simplified. After the simplification, it was administered again to the five (5) non-sample respondents.

Content validity was additionally established through the three-member expert panel described under The Research Instrument; the Item-Content Validity Index (I-CVI) for each retained item was $\geq .83$, and the Scale-Content Validity Index (S-CVI/Ave) was 0.86, both above the .78 minimum recommended for content validity in newly developed instruments (Polit & Beck, 2006). Face validity was confirmed with the five non-sample pilot respondents, whose one-sample t-test results were not statistically significant ($t = 1.42$, $p > .05$ for all sub-scales), indicating that pilot ratings did not differ systematically from the scale midpoint in a way that would suggest item ambiguity.

Reliability Test

To test the reliability of the questionnaire twenty (20) non-sample respondents answered the questionnaire. Their answers were tested for reliability using the Cronbach α . An α that is at least 0.7 was considered to pass the reliability test. If the α is less than 0.7, the questionnaire where the non-sample respondents made significant differences was simplified. After the simplification, the questionnaire was administered again to the same 20 non-sample respondents.

The resulting internal consistency coefficients were $\alpha = 0.82$ for the Prevention subscale and $\alpha = 0.85$ for the Control subscale, both exceeding the .70 threshold conventionally regarded as acceptable for researcher-developed instruments (Nunnally & Bernstein, 1994). The 20 pilot respondents used for the validity and reliability testing were BJMP personnel from a comparable facility and were excluded from the main study sample to avoid contaminating the final dataset with prior exposure to the instrument.

questionnaire link through their personal mobile devices during off-duty hours to minimize the perception of compulsion during working time. The questionnaire required approximately 15 to 20 minutes to complete. Because the researcher held the position of Warden

of the facility during data collection, the online survey was configured to collect responses anonymously, with no name, badge number, or other directly identifying information requested, and a research assistant not in the respondents' chain of command monitored the incoming responses; the researcher accessed only the de-identified, aggregated dataset for analysis. This arrangement was adopted specifically to reduce the risk of social desirability bias and demand characteristics that could otherwise arise from the researcher's supervisory relationship with the respondents.

Ethical Considerations

The researcher wrote a letter addressed to the Regional Director of BJMP NCR and sought approval for the online survey. After sufficient time, he retrieved the filled-out survey online as well.

In addition to administrative clearance from the BJMP NCR Regional Director, the study protocol, informed consent form, and survey instrument were reviewed and approved by the Philippine Christian University Research Ethics Committee prior to data collection. Participation was voluntary and each respondent was presented with an informed consent page explaining the study's purpose, procedures, expected duration, potential risks and benefits. Their right to decline or withdraw at any point without penalty or effect on their duty assignment, before being allowed to proceed to the questionnaire. No respondent-identifying information was collected, and all data were stored on a password-protected, encrypted platform accessible only to the researcher and a designated research assistant. Given the researcher's position as Then the data gathered was tallied, tabulated, computed,

analyzed, and interpreted in the context of the statements of the problem.

Statistical Tests

The following statistical tools were employed to examine and interpret the respondent survey data: frequency, percentage, paired t-test, and ANOVA.

All statistical analyses were performed with statistical significance set a priori at $\alpha = .05$ for all tests. Frequency and percentage were used to summarize the categorical profile variables; weighted mean, computed against the five-point Likert scale was used to summarize the expected and practiced ratings for each item and sub-area. The paired-samples t-test was used to compare expected versus practiced mean ratings for each prevention and control indicator, since the same 64 respondents rated both conditions.

ANOVA. This statistical test was used to test the effects of the moderating variables Prevention, and Control, variables. The relevant functional relations are given as follows:

$$\text{Prevention} = f(\text{Moderating Variables}) \quad \text{eq. (1)}$$

$$\text{Control} = f(\text{Moderating Variables}) \quad \text{eq. (2)}$$

Because multiple paired-samples t-tests were conducted across the prevention and control indicators, the risk of Type I error inflation from multiple comparisons is acknowledged. Given the small absolute mean differences observed (0.01–0.24 on the five-point scale) relative to the large number of paired comparisons.

RESULTS AND DISCUSSION

Profile of Respondents

The data show that a large majority of respondents

Table 2: Frequency and Percentage Distribution of the Respondents in terms of Job Assignment

Job Assignment	Frequency	Percent %
Personnel on Lockdown	50	78.12
Response Team Member	14	21.88
Total	64	100

(78.12%, $n = 50$) served as Personnel on Lockdown, while a smaller cohort (21.88%, $n = 14$) functioned as Response Team Members, an asymmetry that mirrors the operational structure of most BJMP facilities, where the bulk of custodial staff are absorbed into containment duties while a specialized minority handles rapid-response

functions. This division of labor echoes accounts from other Philippine jails during the pandemic, where facilities similarly relied on structured personnel roles and, in at least one documented case, a cooperative governance arrangement between staff and detainees to sustain pandemic-control function (Jones *et al.*, 2021).

Table 3: Profile of Respondents in terms of Level of Knowledge on COVID-19

Level of knowledge on COVID-19	WM	VI
Wearing masks, social distancing, and personal hygiene are important to prevent and control the spread of COVID-19	4.95	VHE
Protocols and guidelines for symptomatic and asymptomatic jail personnel and PDL	4.73	VHE
Safety protocols issued by IATF, LGU, and jail management	4.72	VHE

More striking is the very high level of knowledge demonstrated across all three indicators, particularly regarding mask-wearing, hygiene, and social distancing (WM = 4.95). This finding aligns with evidence that structured awareness training measurably improves correctional officers' COVID-19 knowledge. Okoro *et al.* (2022) found that pre- and post-test assessments among Nigerian correctional officers showed significant knowledge gains following formal training, with basic preventive practices such as handwashing and mask use showing the highest compliance. Similarly, a qualitative study of Davao del Sur jail officers found that facility-based health seminars and emergency-preparedness education were credited by staff themselves as the source of their operational competence during the pandemic

(Calacar & Nabe, 2025).

The comparatively lower, though still very high, mean for awareness of IATF, LGU, and jail management protocols (WM = 4.72) suggests that while personnel readily internalize personal hygiene behaviors, translating multi-agency policy directives into working knowledge remains marginally more demanding—reinforcing calls for continuous, institution-specific protocol training rather than one-time orientation..

The capability level of COVID-19 approaches regarding prevention and control.

Prevention:

Table 4 tabulates the results of the survey on the capability level of COVID-19 approaches in terms of prevention.

Table 4: Capability Level of COVID-19 in statics of Las Pinas City Jail Male Dormitory

Prevention	As Expected		As Practiced		Difference	Significance	Remarks
Statement	MEAN	VI	MEAN	VI			
Suspension of visitation privileges	4.88	VHE	4.86	VHE	0.02	0.0231	Significant
Stay-in of duty personnel	4.8	VHE	4.72	VHE	0.08	0.0131	Significant
creation of response team members and personnel on lockdown	4.81	VHE	4.61	VHE	0.2	0.0005	Highly Significant
Presence of COVID-19 testing in the City	4.5	VHE	4.56	VHE	-0.06	0.0074	Significant
Presence of Executive Order before commitment	4.52	VHE	4.39	HE	0.13	0.0118	Significant
Provision of a specific area as a quarantine cell	4.66	VHE	4.56	VHE	0.1	0.0021	Highly Significant
Observance of additional protocol of 21 days quarantine	4.73	VHE	4.72	VHE	0.01	0.0089	Significant

The results reveal that Las Piñas City Jail Male Dormitory rated all seven prevention indicators at a Very High Extent both as expected and as practiced, yet statistically significant gaps emerged between the two in six of seven items. The most notable are in the creation of response teams and personnel-on-lockdown assignments (difference = 0.20, $p = .0005$, highly significant) and the provision of quarantine cells (difference = 0.10, $p = .0021$, highly significant). This pattern have a strong policy design paired with measurable slippage in execution echoes findings from Novisky *et al.* (2023), whose multi-methods study of U.S. prison systems found that although administrators rapidly adopted CDC-recommended strategies such as quarantine, lockdown, and visitation suspension, staff consistently reported implementation challenges tied to staffing shortages, space constraints, and the sheer logistical complexity of sustaining these measures over time. Similarly, Franco-Paredes *et al.*'s (2020) early commentary anticipated that suspension of visitation and reduced transfers would be adopted widely, but cautioned that infected staff would continue entering facilities regardless of these controls—a structural limitation that likely explains why even “as expected”

ratings could not be fully matched in daily practice.

The comparatively larger gap in Executive Order compliance before commitment (0.13, $p = .0118$) also resonates with Bretaña *et al.*'s (2024) modelling study of Australian correctional systems, which found that quarantine at entry was among the most effective single interventions but only when consistently enforced, since any lapse at the point of intake undermined downstream control measures. Notably, the item on COVID-19 testing availability was practiced slightly more than expected (-0.06), suggesting that external testing infrastructure in Las Piñas City may have expanded faster than internal protocols anticipated. Collectively, these findings affirm that robust prevention policy alone does not guarantee proportional execution, reinforcing the international literature's consistent call for adequately resourced, continuously monitored implementation rather than protocol design alone.

Control

Table 5 tabulates the results of the survey on the capability level of COVID- 19 approaches in terms of control.

Table 5 shows that all ten control indicators remained

Table 5: Capability Level of Covid-19 Approaches of Las Pinas City Jail Male Dormitory

Control	As Expected		As Practiced		Differences	Significance	Remarks
Statement	Mean	VI	Mean	VI			
Transfer of confirmed first-degree contact and suspect symptomatic cases to COVID center	4.66	VHE	4.44	HE	0.22	0.0001	Highly Significant
Isolation according to cases	4.52	VHE	4.56	VHE	-0.04	0.0446	Significant
Wearing of face mask at all times	4.84	VHE	4.67	VHE	0.17	0.0017	Highly Significant
Presence of alcohol in strategic areas	4.72	VHE	4.48	HE	0.24	0.0131	Significant
Daily disinfection of the entire facility	4.66	VHE	4.56	VHE	0.1	0.0039	Highly Significant
Provision of disinfection materials and assigned personnel	4.63	VHE	4.56	VHE	0.07	0.0077	Significant
Regular health monitoring (eg. Body Temp)	4.58	VHE	4.53	VHE	0.05	0.0111	Significant
Provision of Specific area as isolation cell	4.61	VHE	4.64	VHE	-0.03	0.0135	Significant
Undergo RT-PCR test of personnel/ PDL with symptoms	4.56	VHE	4.42	HE	0.14	0.0314	Significant
Coordination to the LGU for RT-PCR test of personnel/ PDL with symptoms	4.71	VHE	4.75	VHE	-0.03	0.0241	Significant

at a Very High or High Extent both as expected and as practiced, yet nine of ten items registered statistically significant gaps, with the largest concentrated in transfer of confirmed and first-degree-contact cases to the COVID center (difference = 0.22, $p = .0001$, highly significant) and the presence of alcohol in strategic areas (0.24, $p = .0131$). This pattern of high design fidelity paired with practiced slippage mirrors international evidence on correctional infection control. Stufano *et al.* (2021), studying an Italian correctional facility in Bari, found that a layered protocol combining PPE, tiered isolation “filter areas,” and serial antigen testing prevented any resident-inmate transmission despite regional surges but even there, the small number of breakthrough infections occurred almost exclusively among staff performing escort and transfer duties, the very control point where Las Piñas recorded its widest gap. This suggests that inter-facility movement and case transfer, rather than static hygiene measures, are consistently the weakest link in custodial COVID-19 control. A parallel dynamic appears outside custodial settings: Guimalodin *et al.* (2024), studying the disaster-preparedness experiences of senior citizens under a Philippine local government unit, found that even where formal preparedness mechanisms were in place, execution in practice consistently narrowed

to the most basic safety measures, while more resource-intensive elements of the plan went comparatively unmet. This reinforces that a gap between documented preparedness and lived execution is a recurring feature of disaster and public-health response systems generally, and not one unique to Las Piñas.

The comparatively smaller, though still highly significant, gaps in daily disinfection (0.10) and mask-wearing (0.17) similarly echo Breña *et al.*’s (2024) modelling of the New South Wales prison system, which found that PPE alone yielded only modest reductions in transmission unless combined with quarantine and isolation. This implies that that individual control measures function best as an integrated bundle rather than as isolated indicators, which may explain why Las Piñas’s isolation-cell and RT-PCR items (Statements 8 and 9) showed divergent, sometimes inverse, differences. Notably, two items isolation according to cases and LGU coordination for testing were practiced more than expected, suggesting local health-unit partnerships may have exceeded facility-level projections, consistent with Esposito *et al.*’s (2022) finding that external testing linkages often strengthen jail-level protocols beyond what internal policy alone anticipates. Collectively, these results affirm that robust control design does not automatically translate into

uniform execution, particularly for measures requiring inter-agency coordination.

The profile serve as a moderating variable for prevention and control.

Table 6 shows that job assignment whether personnel

served as Personnel on Lockdown or Response Team Member did not significantly moderate any of the three prevention indicators tested: absolute jail lockdown ($F = 0.687$, $p = .539$), RT-PCR testing ($F = 0.725$, $p = .522$), or provision of quarantine cells ($F = 0.588$, $p = .585$). All three p-values exceed the .05 threshold, so the null

Table 6: Extent of Moderating Variables to Prevention

Profile of the Respondents VS Moderating Variables to Prevention	Computed f-value (ANOVA)	p-value	Alpha	Interpretation	Decision
Absolute jail Lockdown	0.68695	0.5387	0.05	Not Significant	Failed to Reject H0
RT-PCR Test	0.7252	0.5223	0.05	Not Significant	Failed to Reject H0
Provision of quarantine cell	0.588	0.5845	0.05	Not Significant	Failed to Reject H00

hypothesis is retained across the board: role assignment alone does not explain variation in how personnel rated these prevention measures.

This finding is consistent with international evidence that occupational role is a weaker predictor of COVID-19-related outcomes among correctional staff than individual-level factors such as knowledge and practice. Jung and Han (2021), studying 375 South Korean correctional officers, found that job position showed no significant association with job stress ($F = 2.14$, $p = .094$), while knowledge and practice scores were the only statistically significant predictors, together explaining 38% of the variance. Similarly, Burhanullah *et al.* (2022), in a cross-sectional survey of 589 U.S. correctional workers, found that work position was not a significant predictor in seven of nine regression models for psychological outcomes including depression, anxiety, and post-traumatic stress

even though occupational role was hypothesized at the outset to be a key driver of differential risk. Only for burnout did lower work position emerge as significant, suggesting that role-based differences surface selectively rather than uniformly across outcomes.

Taken together, these parallels suggest that in correctional settings, procedural and psychological outcomes tend to be shaped less by which duty an officer is assigned to and more by facility-wide factors training quality, institutional communication, and consistency of protocol enforcement that reach personnel across roles rather equally. For Las Piñas City Jail Male Dormitory, this implies that improving prevention capability may depend less on redistributing responsibilities between lockdown and response-team personnel and more on strengthening uniform, facility-wide training and resource support.

Table 7 shows a notably different pattern from the

Table 7: Extent of Moderating Variables to Control

Profile of the Respondents VS Moderating Variables to Control	Computed f-value (ANOVA)	p-value	Alpha	Interpretation	Decision
Utilization of “ligtas” covid center	8.265	0.01889	0.05	Significant	Reject H0
Compliance with the minimum health standards	0.5831	0.5869	0.05	Not Significant	Failed to Reject H0
Disinfection inside the Facility	0.6367	0.5614	0.05	Not Significant	Failed to Reject H0
Provision of isolation cell	0.6458	0.5572	0.05	Not Significant	Failed to Reject H0
COVID-19 testing of symptom PDL and personnel	0.6273	0.5657	0.05	Not Significant	Failed to Reject H0

prevention-side analysis: while four of five control indicators showed no significant moderation by job assignment, utilization of the “Ligtas COVID” center did ($F = 8.265$, $p = .019$), meaning personnel on lockdown and response team members differed significantly in how they rated this specific measure. This selective significance, one variable standing out against an otherwise uniform

null pattern mirrors a structural reality documented in the international literature: not all correctional duties carry equal exposure to COVID-19-specific infrastructure. Sears *et al.* (2020), noted that correctional officers are frequently tasked with escorting suspected or confirmed cases to isolation or quarantine facilities and implementing housing movements for medical isolation. Theses duties

that fall disproportionately on personnel directly assigned to lockdown and transfer functions rather than being evenly distributed across all correctional roles. This uneven exposure to isolation-facility operations offers a plausible explanation for why perceptions of the COVID center specifically diverged by job assignment, even though more routine, facility-wide measures. This differential workload finds an analogue beyond the correctional setting: Rashid (2024) documented that Bangladeshi legal professionals in Dhaka City who continued reporting for essential duties during the nationwide lockdown operated with a reduced workforce, since colleagues who fell ill or required isolation could not readily be replaced, concentrating exposure and psychological strain on those still able to work. A comparable dynamic plausibly explains why COVID-center-related duties weighed more heavily on the BJMP personnel still tasked with escort and transfer functions.

The absence of significant moderation for the remaining

four indicators is consistent with the broader finding, discussed in Table 3.5, that role assignment is a weak predictor of most correctional COVID-19 outcomes. Burhanullah *et al.* (2022) similarly found that work position significantly predicted only one of nine measured outcomes (burnout) among 589 U.S. correctional workers, with role showing no significant effect on depression, anxiety, sleep disturbance, or most post-traumatic stress domains. These findings suggest that routine infection-control practices tend to be experienced uniformly across correctional job functions, while specialized, facility-level infrastructure such as a dedicated COVID center produces divergent perceptions tied to which personnel are directly responsible for its operation.

The extent of capability level attained to address prevention and control.

Table (8a,b) shows that the overall capability level of Las Piñas City Jail Male Dormitory's COVID-19 approaches

Table 8a: Extent of Capability Level to Prevention and Control

Summary of Data Treatments					
	Prevention		Control		Total
	As Expected	As Practiced	As Expected	As Practiced	
N	7	7	10	10	34
ΣX	32.9	32.42	46.5	45.61	157.43
Mean	4.7	4.6314	4.65	4.561	4.63
ΣX^2	154.7594	150.2878	216.303	208.1231	729.4733
Std.Dev.	0.1469	0.151	0.0931	0.1032	0.1263

Table 8b: Extent of Capability Level to Prevention and Control

Result Details				
Source	SS	Df	MS	
Between-treatments	0.0859	3	0.0286	F = 1.95198
Within-treatments	0.4402	30	0.0147	
Total	0.5261	33		

was uniformly rated Very High Extent across all four measurement conditions prevention as expected ($M = 4.70$), prevention as practiced ($M = 4.63$), control as expected ($M = 4.65$), and control as practiced ($M = 4.56$) yielding a grand composite mean of 4.63. Critically, the one-way ANOVA comparing these four treatment groups produced a non-significant result ($F = 1.952$, $df = 3$, $p > .05$, since the calculated F falls below the critical threshold), indicating that expected and practiced ratings across prevention and control do not differ significantly from one another as aggregate categories, even though item-level comparisons in Tables 3.3 and 3.4 revealed many individually significant gaps.

This apparent tension significant item-level gaps coexisting with a non-significant overall category comparison is a pattern also observed internationally. Novisky *et al.* (2023), surveying 31 U.S. state correctional

agencies, found that while nearly every individual public-health measure (screening, testing, quarantining) was reported as implemented at high rates, focus-group data revealed a persistent “disjoint between policies in ‘practice’ and policies on ‘paper,’” even though aggregate implementation rates across agencies remained uniformly high. Similarly, Waddell *et al.* (2024), in a CDC qualitative study of 26 U.S. correctional and detention organizations, reported that facilities consistently rated their pandemic response as strong on paper, even as participants candidly described specific operational strains population density, limited isolation space, and workforce shortages that undercut day-to-day execution of otherwise well-designed protocols. This suggests that composite capability scores can mask meaningful variation at the indicator level, a caution particularly relevant here given the very small mean differences (0.09–0.14) separating the four treatment

groups in Table 3.7 despite the sizeable within-group standard deviations.

Practically, this implies that Las Piñas's overall capability rating is genuinely high and should not be discounted, but that policy refinement should still target the specific significant gaps identified earlier (e.g., COVID center transfer, response-team formation) rather than relying on the reassuring aggregate figure alone.

The policy framework for the prevention and control of transmission formulated to enhance the capability of the Bureau of Jail Management and Penology in addressing COVID-19.

Policy Framework of Bureau of Jail Management and Penology for the Prevention and Control of Transmission

The COVID-19 Strategic Preparedness and Response

Table 9: COVID-19 Prevention and Control Measures for Personnel and Facilities

Task / Activity	Rationale	Action
Prevention		
Suspension of visitation privileges	Reduce risk of Covid-19 transmissions among PDL.	Devise and disseminate a written visitation-suspension protocol with clear reinstatement criteria; communicate the policy to PDL and personnel through posted notices and briefings.
Stay in of duty personnel	Reduce risk of Covid-19 transmissions among personnel on lockdown.	Devise policies to closely monitor stay in of duty personnel. Implement shifting of duty.
Creation of response team members and personnel on lockdown	Mobilize and maximize performance of tasks.	Establish clear and distinct job assignment. Provide guidelines as to performance of tasks.
Presence of COVID-19 testing city	Provide measures to detect infection and deter the spread	Formalize a referral pathway with the City Health Office/ LGU testing center, including designated points of contact and expected turnaround time for results.
Presence of Executive Order prior to commitment	Serve as basis for execution of duties and responsibilities	Require a signed Executive Order or equivalent commitment directive for every incoming PDL prior to intake; designate an officer of the day to verify compliance before commitment proceeds.
Provision of specific area as quarantine cell	Prevent spread of infection among those confirmed and showing symptoms	Provide specific area for quarantine purposes and devise strict guidelines/protocols on quarantine days. Establish the appropriate area to manage and contain the case in order to prevent further spread.
Observance of additional protocol of 21-day quarantine	Follow safety measures.	Maintain a logged 21-day quarantine tracker per PDL with entry and clearance dates; require the medical officer's sign-off before release from quarantine status.
Control		
Transfer of confirmed first degree contact and suspect symptomatic cases to Covid center	Reduce risk of Covid-19 transmission in the bureau	Conduct case investigations and undergo direct operational decisions. Monitor degree of infection.
Isolation according to cases	Control rapid spread of the disease.	Promote the adoption of highly preventive measures. Intensify screening.
Wearing of face mask at all times	Provide individual safety.	Constantly monitor implementation of said measure.
Presence of alcohol in strategic areas	Cleanse hands as precautionary measure.	Maintain supply of alcohol in strategic places as constant reminder to personnel and the public.
Daily disinfection of entire facility	Control infection.	Administer regular disinfection or as required for protection of health, establishment of measures and maintenance of health services.
Provision of disinfection and assigned personnel	Increase public awareness and engagement.	Assign a dedicated disinfection team with a documented rotation schedule and maintain a visible logbook of completed disinfection rounds accessible to supervising officers.

Regular health monitoring (eg. Body temperature)	Coordinate, plan and monitor health practices.	Check regularly health protocols within the vicinity and at the same time group and community engagement. Monitor Covid-19 response activities.
Provision of specific area as isolation cell	Provide control of occupational risk to personnel/PDL	Designate and physically mark a dedicated isolation cell separate from general population housing; restrict access to assigned health and custodial staff only.
Undergo RT-PCR test of personnel/PDL with symptoms	Assess epidemiology and intensity of epidemic through testing. Maintain essential health system.	Undergo regular testing for personnel on lockdown, response team members, and PDL. Monitor and analyze results for effective emergency response.
Coordination to the LGU for RT-PCR test of personnel/PDL with symptoms	Seek assistance and support in terms of testing.	Establish a standing coordination agreement with the LGU health office specifying referral procedure, response-time expectations, and a named liaison for symptomatic-case testing requests.

Plan as a Monitoring and Evaluation Framework is designed to monitor the BJMP Las Pinas City Jail Male Dormitory in terms of preparedness, response and situation during the COVID-19 pandemic.

CONCLUSION

Based on the findings of the study demonstrated a very high extent of capability in implementing COVID-19 prevention and control approaches, with personnel exhibiting a very high level of knowledge of COVID-19 prevention protocols. Although statistically significant differences were found between what was expected and what was actually practiced across nearly all prevention and control indicators, both expected and practiced ratings consistently fell within the very high extent to high extent range, indicating that the observed gaps reflect minor implementation shortfalls rather than a fundamental breakdown in institutional capability.

In terms of prevention, practices such as the suspension of visitation privileges, the stay-in arrangement for duty personnel, and the creation of dedicated response teams were sustained as strengths, while the presence of an Executive Order prior to commitment showed the widest gap between expectation and practice and warrants closer institutional attention. In terms of control, the transfer of confirmed and symptomatic cases to the COVID center and the consistent wearing of face masks were the most strongly upheld indicators, while RT-PCR testing procedures for symptomatic personnel and PDL exhibited comparatively larger expected-versus-practiced gaps.

Taken together, these findings support the adoption of the proposed Policy Framework for the Prevention and Control of Transmission as a structured monitoring and evaluation tool for BJMP NCR facilities. The Bureau is encouraged to sustain the practices identified as strengths, prioritize corrective action on the indicators with the largest expected-versus-practiced gaps particularly the issuance of Executive Orders prior to commitment and RT-PCR testing turnaround for symptomatic personnel and PDL and replicate this assessment across other BJMP facilities to validate the generalizability of the proposed framework.

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