# From training to transformation: closing the implementation gap in LMIC leadership

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Dear Editor,

I read with interest Bumb and Chaudhury's article on building public health leadership capacity in low- and middle-income countries, which includes nine initiatives and a three-pillar approach to learner-centric curriculum, adaptive training ecosystems, and multi-stakeholder engagement.[1] Their emphasis on contextual relevance and participatory methods align with current evidence that leadership ability is not merely an innate trait—but a teachable capability.

The authors mention resistance to change and resource limitations, but they do not fully address the key challenge of transitioning from leadership training to sustained practice. Evidence from implementation science shows that without post-training reinforcement (such as peer coaching, workplace projects, and accountability structures), leadership skills decay rapidly.[2]

One practical solution to this is to integrate leadership development into existing supervision and performance review systems. For example, district health managers in LMICs could be required to demonstrate one leadership action (e.g., facilitating a team-based problem-solving session) per quarter, documented in a simple portfolio which is reviewed by their supervisors.[3] Table 1 contrasts traditional versus implementation-focused approaches to leadership training.

**Table 1: Comparison of traditional vs. implementation-focused leadership training in LMICs**

| Feature | Traditional approach | Implementation-focused approach |
|---|---|---|
| Training duration | Short, workshop-based (1–5 days) | Longitudinal (3–12 months) with spaced learning |
| Post-training support | None or optional | Structured peer coaching and workplace projects |
| Accountability | Attendance certificate | Demonstrated leadership behaviors assessed by supervisor |
| Integration with HR systems | Separate from performance reviews | Embedded into regular supervision and promotion criteria |
| Example from literature | Didactic sessions with case studies | Mentored action learning projects |

Furthermore, the authors' reliance on the UTAUT and PLS-SEM methods (referenced elsewhere in the same journal issue) could be extended to measure post-training behavioral intention and actual use of leadership skills. A recent study from India found that only 34% of trained health workers applied leadership competencies at six months without ongoing support.[4]

We suggest adding a fourth pillar: post-training reinforcement systems that link leadership behaviors to routine supervision, team-based reflection, and measurable performance indicators. Without closing this loop, LMIC health systems risk investing in training that never translates into practice.

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