



From Faith to Action: The Rapid Response Team model



Esperande Bigirimana
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*Faith & GBV PBK Practice Lab,
Faith & GBV Community of Practice*



1. Background: The need for faith leader involvement

In November 2013, through sensitisation with the support of Tearfund, survivors of GBV in KwaZulu-Natal (KZN) in South Africa broke their silence publicly for the first time when they shared their stories and lobbied faith leaders to do the same and create safe space for survivors. This was the birth of the *Phephisa Survivors Network (Phephisa)*. 'Phephisa' is an isiZulu word used to express empathy when someone has encountered a very bad and painful experience; it is a comforting word meaning 'Pardon!- You are not alone'.

Phephisa receives numerous reports of gender-based violence (GBV) and have seen firsthand how silence, stigma, and fragmented services leave survivors without support. While many communities in KZN have active survivor support groups formed by Phephisa, there remain many survivors who avoid joining due to stigma. Community members are generally uninformed about GBV and survivor needs, and communities can even be hostile spaces for survivors.

Phephisa is now a peer-led network of over 200 survivors across KZN, with a vision to break the silence surrounding sexual violence in South Africa. It mobilises survivors, runs peer support groups, and creates safer spaces through monthly healing sessions.

Phephisa has five key objectives:

- ☀ Survivors break the silence and speak out
- ☀ Survivors are supported by faith leaders and communities
- ☀ Survivors are involved in a strong peer network
- ☀ Survivors have a better quality of life (psychosocial, economic, health, access to rights)
- ☀ Survivors are engaged in key policy processes.

Realising that many survivors are also people of faith, and that faith communities can be important role-players in supporting survivors and making communities safer for them, Phephisa developed the Rapid Response Team (RRT) model. This approach intentionally brings together survivors, community members, faith leaders, and service providers to address GBV at its source and ensure a coordinated response.

2. The Rapid Response Team model

In 2020, the South African government identified KZN as a [major GBV hotspot](#). In response to this crisis, the RRT model was first established in July 2020 to rapidly intervene and address the urgent needs of survivors. It was then formalised and restructured in 2021 to take on broader coordination and prevention functions. The RRT model is designed around community-level coordination, emphasising multi-stakeholder coordination for unified action, resource mobilisation, mutual accountability, and integrated service delivery.

Rapid Response Teams are local structures created by survivors to close gaps in service provision, bringing together representatives of community-based organisations, representatives from government agencies, faith leaders and other community leaders to provide a coordinated, rapid response to GBV cases. The priority of RRT interventions is placing survivors and their needs at the centre of all services and related work, by referring cases to trusted individuals within the network, reducing delays and preventing the re-victimisation resulting when survivors are forced to repeat their stories multiple times.

RRTs engage community members and stakeholders, creating an enabling environment that is free from violence. They do so through awareness campaigns, community dialogues and outreach programmes that aim to create and maintain violence-free zones and facilities. RRTs also work to influence local planning by municipalities and other organisations, in order to ensure that GBV interventions are prioritised.

As RRT members are deeply integrated into local community monitoring and multi-sectoral planning structures, teams arrange their routine strategic interventions around regular schedules, generally meeting on a monthly basis. It is the responsibility of RRT members to ensure they learn new skills, are trained on new policies, are involved in GBV prevention, and advocate for the rights of survivors.



Faith leaders are important stakeholders in RRTs. They are invited to join RRTs through community dialogues organised by survivors. The purpose of RRT Dialogues is to create open conversations between the survivors and stakeholders about the drivers of GBV in hotspot areas. The goal is to identify these drivers together and determine how stakeholders can work together to address them, reducing risk to all community members and ensuring that survivors receive quality, survivor-centred support and services from all relevant providers.

3. Learnings emerging from PBK harvesting

After years of facilitating RRTs in KZN communities, Phephisa judged it time to reflect on the model and its implementation. It therefore joined a Faith & GBV PBK Practice Lab, run by the SVRI Faith & GBV Community of Practice (CoP). In this Practice Lab, select members of the CoP came together to engage in a structured, supported process to reflect on the lessons emerging from their organisations' work on faith and GBV, through the harvesting of practiced-based knowledge (PBK). PBK harvesting was coordinated by the RRT coordinator at Phephisa, with survivors of GBV, faith leaders, and colleagues participating in interviews and focus group discussions. The harvesting took place between April and June 2026, over a period of three months. This learning brief is the outcome of this process at Phephisa. Harvesting PBK allows for engagement with faith leaders, survivors and coordinators of RRTs as partners, not beneficiaries, to reflect together on what works and what is not working in RRTs.

To ensure the learnings were grounded in lived experience, Phephisa used a participatory, survivor-led approach. PBK was harvested using qualitative methods designed to centre survivor voice and capture the perspectives of all RRT stakeholders.

- Focus group discussion with survivors (20)
- In-depth interviews with RRT Coordinators (4)
- Focus group discussions with faith leaders (2 groups, 10 participants in total)
- Reflection workshop with survivors, coordinators and faith leaders (35 participants)
- Document review (RRT meeting minutes, dialogue notes, referral records, and training reports 2022-2026)

Ethical principles of confidentiality, informed consent, and do-no-harm guided all engagements. Survivors chose whether to participate and could withdraw at any time.

From the PBK harvesting process, three key learnings emerged about the situation of survivors and the realities of working with faith leaders in RRTs. These are discussed below.

3.1 Faith leaders play a key role in RRTs

For survivors, their faith community is often the first and sometimes only accessible space where they feel safe enough to expose their pain without fear. Survivors do not merely look to their faith leaders for doctrinal teaching; they look for active, embodied solidarity that advocate for justice. Despite the systemic challenges and gaps in institutional responses, faith leaders in RRTs emerge as key custodians of community trust. They occupy a unique position, as they serve as immediate, trusted first responders to crises, but also act as spiritual anchors for survivors navigating deep trauma. Their contributions go beyond the pulpit, and faith leaders are useful not simply because they are trusted or influential. When they convert that trust into accompaniment, referral and practical action, they offer practical, psychological, and structural support, providing a unique ministry of presence and spiritual healing that secular institutions cannot replicate. For example, faith leaders physically walk with survivors to police stations to open cases, and sit next to them during traumatic court proceedings. As a survivor shared: "Usually when you are abused, your spirit is attacked and hurt. That is why we see it as a need to go to faith leaders—for our healing." Another survivor emphasised:

"We need faith leaders' support – we really need it. They are our point of reference, because church is where we can be authentic, cry and weep without anyone judging us... Yes, we tithe, we pray and we sing – but we also need someone who will stand with us. Don't just teach us but also stand with us when we need you. That way we will know that God is alive. God is not only in teaching, worshipping and singing – but God is in our lives." (Survivor, Phephisa member, KZN)



Well-sensitised faith leaders recognise their own limitations when dealing with the complex issues of survivors. Rather than working in isolation, faith leaders who are part of RRTs serve as structural conduits, bridging the gap between spiritual care and specialised professional intervention, ensuring that survivors reach trained social workers, psychologists, and legal experts. One pastor reflected on this strategic responsibility:

“Within the church we have professionals that can deal with these issues. For example, social workers, psychologists, etcetera. I need to use these people as a pastor. As pastors our pastoral counselling training has not included dealing with all issues, including these. Hence as a leader, I need to know that when I have just heard of a situation of violence, I can make use of these professionals who can create structures, ministries, because I as an individual may not have enough information regarding that particular situation. But I can create structures that can assist in helping people engage to come to a solution.” (Pastor, RRT member, KZN)

The RRT model has illustrated that, when faith leaders combine their moral authority and spiritual care with professional networks, they have the ability to transform faith spaces into powerful hubs of justice, protection and holistic recovery.

3.2 Faith institutions can challenge GBV prevention and responses

Discussions with both survivors and faith leaders who are members of RRTs revealed that faith leaders and institutions can, unfortunately, also be problematic when it comes to addressing GBV and ensuring survivor care and support. In some churches, leaders protect one another, and complaints or allegations brought by survivors disappear without action. It is even more of a challenge when the perpetrator is a member of the church. Some leaders cover up incidents to keep them private. Survivors leave the church out of shame, and cases are forgotten while the wounds remain. Support may also become conditional when survivors are not members of that congregation, undermining the RRT’s goal of consistent support for all. Involving faith leaders does not itself create a survivor-centred response, as existing hierarchies, institutional loyalty and theological framings can reproduce harm unless there are safeguards and accountability mechanisms.

While their faith communities are often the first place survivors turn to when their spiritual well-being is affected, not all faith leaders and faith communities are receptive to and supportive of survivors.

“The church has become sometimes so holy that you can’t raise the issues of violence that you experience at home. When we pray in the church as women, the faith leader can sometimes think the Holy Spirit is very high today when we as women – we are just crying for our issues... and we are saying ‘Oh God, this husband of mine’, we’re just cry(ing) about what we are experiencing. We do have so many issues that we are struggling with. We don’t talk about these issues in the church because we are told they are not related to church but to community and family that should be dealt with outside the church – when we speak to some faith leaders- not all”. (Survivor, Phephisa member, KZN)

“We are told ‘this is a demon, so don’t speak about it... The devil will be happy. Just sit on it.’ So you sit on top of it and nurture it, because nobody will approach it. Even church leaders are afraid, so we continue to hide it with the hope that things will change.” (Survivor, Phephisa member, KZN)

For many, the church has become too holy to raise issues of violence within households. Survivors are told to “bekezela” — be patient — and trust that God will provide a way. And while some faith institutions may preach about GBV, they do not do anything more. For example, a pastor shared that this church preaches against GBV and provides safe spaces and clinical pastoral care. But he noted a common limitation, namely that many pastors only preach against GBV, but do not do anything concretely to protect survivors.



3.3 What makes faith leader involvement in RRTs work

Reflecting with RRT members from various communities has identified two elements as critical to ensuring that faith leader involvement in RRTs work effectively.

The first element is power sharing. The RRT model is built on the premise that survivors should be in control of their healing journey; while various stakeholders are involved in supporting them when needed, in the final instance it is the survivor who makes the decisions. However, experience has shown that, at times, this power is taken away by faith leaders who are used to being the ones in control. In several cases, faith leaders involved in a RRT took control of a case without considering the survivor's wishes, e.g., by pushing for forgiveness before the survivor is ready to forgive, or by replacing formal reporting with internal disciplinary process when the perpetrator is a faith leader or prominent church member. These processes lack transparency, and survivors are left without justice or closure.

When survivors have power in decision-making, responses are shaped by their needs, and the RRT's activities and interventions become more effective. It is therefore important for faith leader members of RRTs to be consistently reminded that support is a survivor-led process, and for the other RRT members to speak up if faith leaders take over. All RRT members are responsible for protecting survivor leadership. For example, the RRT coordinator is responsible for directly checking with each survivor before a particular action is taken, by literally asking "Is this what you want to happen" and documenting the survivor's response, transcribing the survivor's actual words and not the coordinator's interpretation of it.

The second key element to ensuring that faith leader involvement in RRTs is impactful, is to ensure their capacities are continuously developed and expanded. Faith leaders are trusted community figures and having them as members and the public faces of the RRTs has made it easier for communities and stakeholders to accept the initiative. However, to ensure that faith leaders are willing to join and support RRTs requires sensitising faith leaders on gender justice and GBV. Many faith leaders initially do not understand these issues, nor the urgency of it. Setting up dedicated gender desks within churches can be helpful, as this helps ensure that a church's involvement and engagement with a RRT does not solely rely on their faith leader, and contributes to transforming the entire church and faith community into safe spaces for survivors. The PBK harvesting showed that changing the attitudes of faith leaders, especially those initially resistant to GBV issues, does not happen through once-off training. What works is a relational, long-term approach grounded in lived experience, with repeated engagements. The ongoing relationship builds trust and allows difficult questions to be raised without shame. Survivor testimonies can be a crucial component of this process, if done safely and on survivors' terms. The PBK harvesting revealed that faith leaders experienced survivor testimonies as very powerful, especially when survivors chose to share their stories about how faith had both harmed and helped them. It moved faith leaders from abstract thinking to lived accountability.

4. Conclusion

Within the Rapid Response Team model, faith leaders serve as trusted entry points, mobilisers, and accountability partners. Their influence can enable survivors to access services faster, may assist in reducing fear of reporting, and can help shift harmful norms in communities where the church holds moral authority. The PBK emerging from the process of reflection with survivors and RRT members has highlighted that the continuous engagement, awareness-raising and training of faith leaders on gender justice and GBV is crucial to ensuring their active involvement in RRTs. When faith leaders and survivors share power, accountability becomes possible, cases are responded to, and churches become safer spaces.

Phephisa believes that their experiences and learnings with the RRT model hold multiple lessons for practitioners working in similar contexts where faith holds influence. It is crucial that the process remains survivor-led and grounded in practical, agreed-upon actions. Ending GBV requires all stakeholders—community members, faith leaders, government, and civil society—to work together and uphold the dignity of every survivor. As one faith leader put it:

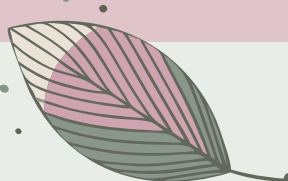
"If that power is given to survivors in decision-making, it will lead to a sustainable way of dealing with the challenges of gender-based violence. And prevention strategies will finally make sense." (Faith leader, RRT member, KZN)



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svri@svri.org



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