CURRICULUM VITAE

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Present Positions:.1- Professor of Genetic in Federal University of Rio de Janeiro. Chief of the Laboratory of Molecular Virology at the Institute of Biology , Federal University of Rio de Janeiro, Brazil.

2-Associated Research Scientist at Mailman Scholl of Public Health, Columbia University, NY; Located at Dean Office and serving the ICAP Program.

Education: M.D. - 1982. Federal University of Rio de Janeiro
Medical School
Major: Medical Degree
Master in Biophysics – 1985. Federal University of Rio de Janeiro
Instituto de Biofisica Carlos Cahgas Filho.
Thesis: “Isoenzyme variation in clones of *Trypanosoma cruzi.”*
Ph.D. - 1990. Federal University of Rio de Janeiro
Darcy F. de Almeida, MD, Ph.D., Professor and Head
Microorganism Genetic Laboratory.
Thesis: "Expression of an active foot-and-mouth disease virus RNA polymerase in Escherichia coli. "
Sabbatical - 1995/1998.
Mark Rayfiled, Ph.D, Chief, Cell Biology Section
Laboratory Investigations Branch, DASTLR, NCID, at Centers for Disease Control and Prevention.
Theme: HIV genetic variation in Brazil. Generation of intrasubtype recombinant in vitro.

International Experience

1/2001- Participation in the Workshop for Implementation of HIV Resistance Network , WHO/IAS. Rome, Italy, 2001.

11/2001/Present- Participation as Brazilian site on the pilot study of the HIV Resistance Network , WHO/IAS.

2/2001- Participation In The 1st Workshop for Strength African Laboratory Capacity, AFRO/WHO, Harare, Zimbabwe.

3/2002- Participation in the pilot phase Implementation of HIV Resistance Network , WHO/IAS.

2001/2004- LIFE Initiative (GAP) Program Consultant.

2001/Present- Mozambican Ministry of Health Consultant for HIV diagnostic.

2000- UNAIDS HIV Drug Resistance Workshop, Instituto Carlos III, Madrid, Spain.

2000- Participation as a Brazilian site on UNAIDS Drug Resistant Pilot Study in Latin American Countries.

2003- Chairman of the study design working group for WHO, Geneva. This working group defined the WHO Resistance Network Guideline. This document defines how WHO will face the problem of HIV drug resistance all over the world.

1998-present- Act as reviewer in several international scientific journals (Lancet, Journal of Infectious Disease, AIDS, and Journal of AIDS)

International Service:

I- 2003-2005: Senior Service Fellow at GAP-NCHSTP, Center For Disease Control and Prevention, Atlanta, GA. In this program I am working together with the Presidential AIDS Initiative (PEPFAR) helping Mozambique and Rwanda to establish a laboratory network to monitor the AIDS patients treatment in those African countries. As a Senior Service Fellow at GAP-NCHSTP, Center For Disease Control and Prevention, Atlanta, GA. Specific task have been accomplished in four African countries:

Angola-

a) Helped the Angolan Ministry of Health to evaluation of Rapid Tests and define a national algorithm for HIV testing

b) Assisted the Angolan Ministry of Health in the 2004 ANC survey.

c) Participate as professor and organizer in the 1st Training on Antiretroviral Use in Angola.

d) Helped the Instituto de Saude Publica, Luanda to organize a molecular biology laboratory which is routinely performing HIV virus load , infant diagnosis, and HIV genotyping.

e) Helped the Angolan Ministry of Health during the recent Marburg outbreak to establish a molecular biology lab for rapid diagnosis of Marburg infection through real-time PCR

2. **Rwanda**-

a- Helped TRACK to define the Lab Network for the MAP/World Bank Program.
b- Participated in the installation of the 13 laboratories from MAP sites in three country provinces. The treatment and laboratory components of the Multi approach AIDS Program (MAP) have been recognized by World Bank management in a "results showcase" competition. CDC Rwanda team is among the only non-Bank participants to receive this award. The strategic partnership between the World Bank and CDC has certainly been invaluable in the design and implementation of the treatment program in Rwanda.
c- Helped Rwanda Ministry of Health and CDC Rwanda to develop the laboratory section Presidential Emergency Program for AIDS Relief (PEPFAR) Five Years Laboratory Plan.
d- Participate together with Columbia University in the evaluation of DBS for infant diagnosis through PCR. This was a successful initiative and the country is planning the implementation of national program using this device.
e- With the TA of CDC, and MCAP, NRL-Kigali was able to produce, validate, and pilot a new QA/QC program for the VCT and PMTCT using a dry plasma spot (DPS) specimen format.

3. **Mozambique**-
a- Helped the Mozambican Ministry of Health (MISAU) in evaluating Rapid Simple Tests in Mozambique and defined a national algorithm of HIV testing in Mozambique.
b- Helped MISAU to define the Lab Network for the PEPFAR Program.
c- Helped MISAU to define QA program for Rapid Simple Test in 84 VCT centers.
d- Helped MISAU to define the Lab Network for the PEPFAR Program and advised the MISAU to went in a reagent rental model.
e- Helped MISAU and APHL to organize the procurement for the PEPFAR laboratories.
f- Helped MISAU and CDC Mozambique to develop the laboratory section (PEPFAR) COP04, COP05 and the Five Years Plan.

4. Botswana-
a- In Botswana CDC has a nice PMTCT program in Francistown where we could add the infant mol testing using dry blood spot (DBS). We have trained the nurseries and the lab tech in Botswana Public Health Lab, and implemented the DBS testing. In one month of the program more than 500 samples was tested with a turn around time of 8 days (the past one was 90 days with whole blood).

II- 2006- Present; Associated Research Scientist at Mailman Scholl of Public Health, Columbia University, NY

As a CDC (Track 1.0 and UTAP) and USAID PEPFAR partner, ICAP provides support in 10 countries to adult and pediatric care and treatment using a family based health care. In this scenario the laboratory development

has to follow a networking model where different tier laboratories are linked to give kind of tests needed to follow-up the patients under ARV therapy. Lab services should be close to clinical sites to facilitate the access to large menu of tests. Sample transportation should be avoided, and lower tier labs linked to higher tier labs to provide access to more specialized tests. In 6 out of 10 ICAP countries (Mozambique, Nigeria, Ethiopia, Tanzania, Kenya, Rwanda, and South Africa) a lab network was established and 109 lab has been upgraded with major improvement in their infrastructure, new equipments, and supplies. Presently, these labs are giving support for the 146000 HIV+ patients in our sites. In 2007 an additional 48 labs are planned to be developed. In Rwanda ICAP could help the MoH to implement an comprehensive QA/QC program targeting at all tiers giving support to National Reference lab in Kigali. Rwanda case is an example how important to use of in-country Reference Laboratory to organize QA/QC programs providing internal QA/QC (re-testing) as well external QA/QC for CD4, and HIV serology. Besides the general clinical lab development ICAP Lab Regional Section was requested to help Ethiopia, Rwanda, Tanzania, Mozambique, and Eastern Cape (SA) to establish the early infant diagnosis using PCR in DBS samples collected direct from heel and toe prick. This was successful program and unable an substantial number of kids < 18 month have access to ARV.

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