

The Malaria Capers: Tales of Parasites and People: More Tales of Parasites and People - Research and Reality

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The

Malaria

Capers

More tales of parasites and

people, research and reality

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For Carrolee

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The years had imposed other changes. The soaring spirit houses, the *haus tambarans*, were gone, destroyed at the insistence of the ever-growing influence of fundamentalist Christian missionaries. Later, a villager would take me, conspiratorially—one heathen to another—to a *haus tambaran* deep in the jungle; hidden from the missionaries and their God. It was a sorry bush structure with little of the superb artistry and artistic value of their traditional houses of worship. One old man peered at me and said he remembered my last visit twenty years ago, but he thought I had changed “lik lik.” Obviously, he must have been thinking of someone else. No other old-timers remembered me. There weren’t many old-timers. Life is not long in New Guinea’s East Sepik region.

In Salata, that first day of return, we worked through the heat of the long day: Ray Spark in a deer stalker hat, his butterfly net at the ready beside him, taking blood films and chatting up the villagers in flawless pidgin; George Anian, a Papua New Guinean research associate, the painless blood drawer, taking serum samples; myself, palpating abdomens to feel for the malaria-enlarged spleens—no problem in children but more difficult in the muscular, ticklish adults.

“Breathe in” (*holim win*)—giggle, giggle.

By the end of the day we knew that nothing had changed in Salata; malaria was as it had been twenty years ago. Later examination of the stained blood films in the laboratory not only confirmed our first assessment based on the percentage of people with enlarged spleens but also revealed that malaria was now more prevalent, less treatable, less controllable than in 1962. Moreover, the adults, who in former times were clinically immune, had lost that hard-earned protection and now were frequently feverish. An adjacent control demonstration village, Bumbita, in which malaria had been reduced to negligible endemicity in 1964 by intensive spraying with DDT and mass antimalarial drug administration, was now like Salata—highly malarious. Nor was it only malaria that remained unwholesomely unchanged. There was a new generation of snotty-nosed kids with their upper respiratory tract infections. Hardly a clean skin could be seen in the village; almost everyone still had the thickened, horny “puk-puk” (crocodile) skin of the *tinea imbricata* fungus infection.

There are many “Salatas” throughout the tropical world where health and health systems have deteriorated during the past twenty-five years. These are villages in the poor nations that have not benefited from the massive largesse of Western charity. These are Salatas which have not benefited from the medical research, research of unimpeachable intellectual quality, carried out in Western biotechnology establishments. Tropical Africa is the “Great Salata.” It has been virtually untouched by, or responsive to, antimalarial and other public health programs. In 1984, the year we were making our resurvey of Salata, the Nigerians published their own plaintive report: “Despite health delivery care, parasite [malaria] rates in Nigeria are the same as in 1934. Only 1% of the population is covered by vector [mosquito] control.” Even so, from 1934 to 1954 tropical Africa, with all its sleeping sickness, its 40 percent childhood mortality from malaria and malaria-related disease, its schistosomiasis, its tuberculosis, its meningitis of many kinds, and its dysenteries of many kinds, was relatively healthy. “Relatively” because now Africa has AIDS. The virus is killing off great masses of Africa’s peoples.

Africa is the continent of sorrows where one disease feeds on another and it is where malaria is bringing AIDS to its children. Young children are particularly at risk to becoming infected with acute life-threatening malaria. That threat is now even greater because of the recent appearance of drug-resistant strains. One of the most common consequences of childhood acute malaria is an anemia so severe that a blood transfusion is required to save the patient’s life. Dying children are brought to hospital for blood transfusion. In hospital they get transfusions from donors whose blood has not been tested for antibody to the AIDS virus. No such screening can be performed in the simple laboratories of African health centers despite the need—over 30 percent of the adult

population may have the AIDS virus in their blood. In this way the children come into the hospital with malaria and leave with AIDS.

Thus, during the past two decades when biotechnology has made so many stunning advances, the health of tropical peoples has worsened. Eradication and control schemes have collapsed. Old, proven therapies have become impotent in the face of drug-resistant microorganisms. New, affordable, non-toxic chemotherapeutics have not been developed; a drugs-for-profit pharmaceutical industry gives low priority to the diseases of poor people. So, too, with insecticides; arthropod-borne diseases (malaria, yellow fever, sleeping sickness, filariasis, dengue fever, Chagas' disease, Japanese B encephalitis—to name a few), once controllable by long-acting insecticides (notably DDT), have lost their power by reason of insecticide-resistant insects and insecticide-resistant health authorities. Expertise has been lost; the last generation of truly experienced "field hands" are leaving the scene, lost to age and disuse. They are being replaced both in the West and in the research centers of the tropics by the "molecular types," more concerned with the exquisite intellectual challenges of modish science than with seeking practical solutions. The razzledazzle and promise of biotechnology have led Third World health officials to expect the quick fix—the malaria vaccine "just around the corner," the genetically altered mosquito that yesterday's press release proclaims will be the last word in controlling vector-borne diseases; and, confusing diagnosis with cure, the DNA probe techniques to detect parasites even at clinically insignificant levels.

That is the weft of our story. There is an imbalance, a discontinuity between research and reality. This is an imbalance that has inhibited improvement in the health of tropical peoples; but in addition, I believe it has actually contributed to the deterioration of health. The warp is formed by the story of two great tropical diseases, kala azar (visceral leishmaniasis) as it occurs in the Indian subcontinent, and malaria as it now occurs, and where it formerly occurred, throughout its near-worldwide endemic dominion. These diseases will serve as examples of the tropical world's state of health. We will follow each of these insect-transmitted infections through the course of their natural history, human history, and the historical events surrounding their elucidation by sometimes great, sometimes petty, and sometimes venal scientists.

Let us begin by imagining ourselves in an impoverished kala azar-stricken village. It is April and . . .

1. See [chapter 14](#), "Unseemly Behavior," in Robert S. Desowitz, *New Guinea Tapeworms and Jewish Grandmothers: Tales of Parasites and People* (New York: W. W. Norton, 1981).

I

[*Kala Azar: The Long Anguish of the Black Sickness*](#)

[Chapter 2](#)

[A Child Dies in a Small Village](#)

THERE ARE no words to tell you of the heat that consumes the Ganges plain during the months when the winter has left and the monsoon rains not yet begun. No shadow falls from the cloudless sky. Every breath is searing. A torpor settles over the villages strewn throughout the hard, stubbled fields. Children are subdued, adults languish on their charpoy beds, and even the cattle seem immobilized.

On one such burning day in April, in a village in Bihar, Susheela Devi was worried about her sick child. Susheela, a tired-looking woman in a tired-looking sari, is middle-aged at thirty-two years. She was given away in marriage when she was thirteen. Burdened by work, harassed by a bitter mother-in-law, and uncared for by a husband twenty years her senior. That crone mother-in-law still complained that Susheela had not brought sufficient dowry into the family. This was dangerous muttering. Other village wives had fatal "accidents" and were replaced with younger wives and new dowries. Her decision to seek medical help required brave determination. There was the overpowering heat through which she would have to walk, carrying her sick child most of the eight miles to the government health center. The peasant poor of India do not squander their precious rupees on the luxury of bus or bicycle rickshaw unless there is a great emergency. The child was ill, but not emergency-ill in any of the too familiar life-threatening ways . . . the acute fever and coma of childhood malaria, the rapid wasting diarrhea and death of cholera, or the labored gasps of pneumonia. It was merely that the child seemed somewhat feverish this past month and was becoming emaciated, despite a reasonably good appetite, with a distended abdomen like the children of the failed-monsoon famine years.

Susheela awoke before dawn the next morning; cooked the family's food for that day—some rice and a bit of curried river fish. She led the cow from the stall, which was attached to the house as a kind of guest room, and gave it some fodder. The cow was indeed an honored guest. The mount of Lord Siva as he rode through the cosmos and his audience when he danced, it now gave milk and *ghee* to this poor family. Its dried droppings were the chief source of fuel in the deforested plain. The very substance of the house's mud walls was the excrement from this holy beast.

The fitfully sleeping child was roused as the first light began to appear in the eastern sky. Mother and child left the village to begin the long walk to the health center. They were not long on the road when the sick child could walk no further and the 90-pound mother began to carry her child mile after painful mile. Three hours later, when the sun was rising above the neem trees, the exhausted Susheela arrived at the health center. It was about 9:00 a.m.; already more than one hundred people waited. They filled all the benches on the center's veranda. The overflow, joined by new arrivals, sat on the open ground surrounding the health center.

Susheela sat amongst the outside group. Many were mothers with their sick children, but more were men. There were men with open wounds. Accidents from road and agriculture take as heavy a toll as malaria and other infectious illnesses. Women were but women; they had to be sicker than men to leave their work to go to the health center. The waiting patients were mostly silent, not unlike the withdrawn silence of our own physicians' waiting rooms. A half hour later the two doctors assigned to the health center arrived. They looked so young and, to Susheela, so different from the young men of her village. And they *were* different. They were born in the city, schooled in the city, medically educated in the city, and clinically trained in city hospitals. Upon graduating, they were forced to work a year or two years at a rural health facility. The shorter time (or no time) if their family was well connected. And as soon as they finished their country time they would be back in the city, scrambling against an excess of physicians to establish a practice. Only a few well-trained doctors chose to serve these non-paying country peasants. Their family would have to be conspicuously "unconnected" to be left in *that* limbo.

The hours passed. The heat intensified. Susheela and her child remained fixed to their bit of ground, afraid to leave even for water lest it be usurped by another of the ailing. Shortly before

noon, a health center attendant who had been circulating amongst the waiting people, registering their names, came to Susheela and whispered that within the hour the doctor sahibs would leave for their lunch and would not return since in the afternoon they conducted their business seeing paying patients at their private clinics in the town. However, he confided, for 10 rupees (about 50 cents) he could arrange for her to see one of the doctor sahibs, the smart one, within the hour. Susheela was stunned by the demand, but not surprised; these privileges must always be bought from the petty government servants. From her small hidden reserve banked in a secret recess of the wall by her pallet she had withdrawn 7 rupees, half her "account," to take with her. She had decided to use it for bus or bicycle rickshaw to take her back home. She felt she just had no strength left to carry her child those eight miles. That would not now be possible, and she offered the attendant all she had, the 7 rupees. He grumbled and reluctantly agreed to accept the bribe, but for such a paltry sum she would not be able to see the smart young doctor sahib who had been at the health center for six months. She would have to be attended to by that ninny who had just graduated from medical school and had been posted to the center only two weeks ago. The precious few coins were handed over, a day's wages for many peasant laborers.

The attendant, fortunately, was an honest man and good to his bribe. Within a short time he called Susheela's name to enter the doctor's cubicle. The young doctor was brusque, unfriendly and uncommunicative. He was unsure of his skills but sure of his importance in being a doctor. He felt alien in this country setting and so he adopted the manners, experienced since childhood, in dealing with social inferiors—brusque, officious, and unfriendly.

He told Susheela to put her frightened child on the bare wooden examination table. This done, the doctor prodded the child's distended abdomen, his fingers sensing the greatly enlarged spleen and the enlarged liver whose boundary was well below the rib cage. The thermometer revealed the child's temperature to be 101°F. Without preliminary explanation he took the child's arm and swabbed it with an alcohol swab, which came away black with grime and sweat, and then, while the attendant took a tight grip on the thin arm, the doctor stuck a syringe needle into a vein. The procedure really didn't hurt that much, but for the frightened, apprehensive little girl, who had been to this moment so stoically uncomplaining, the sight of blood welling into the syringe barrel produced a shriek, followed by uncontrollable sobbing. A river of sad tears washed the small, pinched face. Susheela did the best she could to comfort her child and was told to wait in the corridor while the blood was sent to the laboratory to be tested.

The health center's laboratory was a small, dimly lit, not very clean room, cluttered with broken but still usable bits of glassware such as microscope slides and test tubes washed innumerable times, and some basic reagents to perform basic, all-important tests: blood counts, staining for malaria parasites, and the presence of abnormal sugar and protein in urine. There was also a microscope of Polish manufacture whose optics, not of good quality to begin with, had acquired a bloom of glass-loving fungus which gave a blurry, chiaroscuro image to the scrutinized malaria parasites, worm eggs, and other microscopic faunal and floral parasites.

The syringe was given to the laboratory technician, who expressed the blood into a glass centrifuge tube. On the floor in a corner of the laboratory, almost hidden in the gloom, sat an old man clothed only in a ragged dhoti. This peon was the centrifuge wallah, and it was now the moment for him to do his work. The health center had no electricity. The microscope was illuminated by the light that filtered through a shuttered window, and the centrifuge—a simple, motorless instrument—was propelled by means of a hand crank and gears. The centrifuge wallah cranked vigorously, spinning the blood tube some 1500 revolutions each minute. After five minutes, the cranking stopped and the machine came to rest. The centrifuge wallah returned, wordlessly, to his place in the corner.

In the tube, the centrifugal force of spinning had separated the blood into its components, a

bottom layer of packed red cells above which there was a thin stratum of white cells. Over the packed sediment of cells was the straw-colored fluid—the serum. In normal, healthy people, there should be an almost 1:1 ratio between the volumes of packed red blood cells and the serum. But in this specimen, the technician noted that the tube contained only about 25 percent in packed cells. The child had only about half the red blood cells that was normal . . . a case of severe anemia. Then the technician transferred a few milliliters of the serum to another tube. To that tube he added a few drops of formaldehyde and vigorously shook the mixture for a few seconds. Within minutes the serum began to solidify into a Jell-O-like clot. This was an abnormal reaction that occurred only when a very great amount of gamma globulin was present in the serum.

To the doctor, the constellation of signs and symptoms could point to only one diagnosis. The prolonged fever, the greatly enlarged liver and spleen, the anemia, the serum that gelled when mixed with formaldehyde, all meant visceral leishmaniasis, a disease that both peasant and physician knew by its vernacular Mogul name of *kala azar*—the “black sickness.” Realizing the gravity of what he was about to tell Susheela, his pomposity fell away. The young man had not yet hardened to his role as death’s messenger. “Mother,” he said gently, “your child is very ill with *kala azar*.” The words made Susheela gasp and her eyes stung as if she had been struck with great physical force. The people of her village and the other villages of the district were no strangers to *kala azar*. The disease had reappeared some ten years ago, to begin killing old and young alike, but mostly the young. Before that time, her generation was ignorant of the disease, although the old men of the village spoke of former times, during the days of the British Raj, when great epidemics of *kala azar* ravaged Bengal and Bihar, the Terai of neighboring Nepal, decimating villages, towns, and cities. Susheela’s child was a new victim of the new epidemic.

With urgency, the doctor continued: “It does not mean death. Your child can be cured. You must buy medicine. Then you must come here every day for twenty days so the nurse can inject the medicine. Every day! Not a single day must be missed!”

The word that echoed in Susheela’s head was “buy.” *Buy?* Buy medicine? She had brought her child to be treated, not to be given a few words of advice. She had walked those miles, sat for hours waiting in the sun; she had paid her bribe—every rupee she had—to see the doctor. Now she was told to buy the medicine that she expected the health facility to provide her.

“Cannot I get the medicine from you, doctor?”

“No,” he replied. “We have no *kala azar* medicine. The state government in Patna gives our dispensary only a few simple medicines to treat a few simple illnesses. Last year we had some *kala azar* medicine, but there were many people to be treated and our supply was soon finished. We’ve written again and again to the central medical stores in Patna for more drugs, but they do not even reply to our letters. Now everyone must buy the medicine where they can and as best they can.”

“What will it cost?”

“That I cannot tell you. If the pharmacist has a good stock, it will be cheaper; if not, it will be expensive.” He scribbled a prescription on a scrap of paper and, reverting to his customary brusqueness, thrust it at Susheela, peremptorily dismissing her with “Unless you get the medicine there is nothing more I can do for you. Go now!”

Susheela made her way through the crowded market until she found the druggist’s shop. She handed him the scrap of paper on which the doctor’s prescription was written and the druggist told her that she was indeed fortunate because there were only two bottles of the *kala azar* medicine left. Many people in the district had the disease and needed the medicine.

“How much is it?” Susheela asked fearfully.

“Mother,” replied the druggist, “I know that you are poor and your child is ill. For you, I will give you a bottle of the drug, enough for her whole treatment, for three hundred rupees [about \$15]. Others I would charge five hundred rupees.”

Three hundred or 500 rupees; it made no difference. It was an astronomical sum, more than the family’s income for some months. Susheela picked up her child, turned from the pharmacist, and began the long walk back to her village.

It was well after dark when she reached home. There is no purpose in recounting the abuse she received from her mother-in-law and her husband for being away from her duties for an entire day . . . that was too customary. Later, as they lay on their sleeping mat in the darkness, Susheela told her husband what had happened that day. They must buy the medicine. But how? Sell the cow? If they did that, then surely the family would starve. Borrow from the land-owner from whom they leased their small plot of rice paddy? Impossible. They were already in debt to him for almost half the future crop to pay the lease rent and to repay the loan he had advanced to buy seed and fertilizer. There were no family resources. Each relative was as poor and indebted as themselves. Even if by some miracle they could buy the medicine, there was no way that Susheela and the child could travel those long miles to the health center for twenty consecutive days. Not only, she knew, did she lack the strength but the monsoon rains would soon begin and it was essential that she help prepare the soil and plant the rice. The family’s precarious survival required the labor of each member at planting and harvest. No, for the child they would have to do the best they could. They would pray to the gods. They would consult the “doctor” in the adjoining village, a man who practiced Ayurvedic herbal medicine.

In the weeks that followed they prayed at the small village shrine, leaving offerings of food, as if the gods too were petty bureaucrats who had to be bribed. The Ayurvedic doctor did not miss the diagnosis of kala azar and for a few rupees gave the child some herbal medicine that for over a thousand years had been prescribed for fevers. And indeed, for a short few days after taking the draught, the child’s fever abated and she brightened. But in the end, as the weeks passed, she became progressively more ill: she grew even more emaciated, her skin turned a dusky gray, her hair became brittle, small bleeding sores covered her body, and the abdomen, burdened with a grossly enlarged liver, distended even further.

One day, some three months after Susheela’s visit to the health center, the child began to cough and gasp for breath. During the night, the little girl died.

The mourning family carried the small body on a wooden plank, draped with a bit of cloth and adorned with marigolds, to the banks of the Ganges. There at the burning ghats the body was offered to the fires. A fragment of life sacrificed for want of \$15.

For the family there was some comfort. There were seven other living children. And, by good fortune, it was not a boy that had died.

[Chapter 3](#)

[How the Government Disease Came to India](#)

THE INSTRUMENT WHICH consigned Susheela’s daughter to the funeral pyre was a tiny midge, no weightier than an eyelash. In Patna, the capital of Bihar State, fifty miles from Susheela’s village, Dr. A. K. Chakravarty was holding a cage in which these silver-winged insects were quietly resting

on the screened walls. "They look so innocent" was his brooding observation on the treachery of appearances. Chakravarty is the chief of India's National Institute of Communicable Diseases' Kala Azar Unit, based in Patna. He is a large man, well over 6 feet tall, and despite his determined, rather ferocious countenance, he is of gentle nature: a devout Hindu, given to philosophic enquiry into human spirituality; veterinarian-researcher (more later of why a veterinarian should be in charge of a unit conducting studies on a human disease) who treats his animal and human patients with a delicate, kindly courtesy. The objects of this disproportionate encounter between man and insect were the blood-sucking sandfly midges, *Phlebotomus argentipes*. As the anopheline mosquito is the biologically required transmitter of human malaria, the phlebotomine sandfly is the purveyor of another killing parasitic protozoan, *Leishmania donovani*, the cause of kala azar.

Of all the parasites, great and small, that make our bodies home, the *Leishmania* may well be the most peculiar and intractable. To the invaded host, a parasite is a foreign body calling for a response. A major effector mechanism of immune defense is the killing and devouring of the parasite by specialized wandering and fixed cells, the front-line soldiers of the immune system, known as phagocytes. The *Leishmania* have the effrontery not only to evade digestion by the phagocytes but actually to invade them in an obligate fashion to become intracellular parasites.

The parasite was but one factor that led to the funeral pyre of Susheela's child. Her tragedy was an interweaving of parasite and its sandfly transmitter; climate and culture; society, medicine, and politics. Let me take up the thread of this complex of interrelationships by examining the history of the *Leishmania* and the disease it causes—kala azar.

To understand the history of kala azar (or any other human disease), we must keep in mind that our "files" go back only a few thousand years . . . to the beginning of written language, the beginning of the human documentary. There are a few mummies and ancestral bones from which the medical archeology detectives have gained sparse clues into the nature and epidemiology of ancient illnesses. However, humans must have thought about their health from that imperceptible time when they became truly human—an animal with the cognitive sense of well-being, and of illness and the certainty of death; an animal with the gift of foresight. Health and disease was an issue to our ancestors as it is to us today. When the ancients devised the written word, they wrote about their illnesses—in hieroglyphics—in Sumerian, Babylonian, Arabic, Greek, Latin.

All early written languages seem to have had their "medical books," although notions of disease causation were very different from ours. Microbes and such are new to the medical profession. Before the first microbe could even be discovered there had to be a good microscope to see them by, and not until about 1825 were achromatic microscope lenses available. Then someone with extraordinary insight had to put two and two together to recognize, for the first time, that so minuscule an organism could be the specific agent of a specific disease. Only in 1875 was a protozoan shown to be a pathogen. This was *Endamoeba histolytica*, the cause of amoebic dysentery and amoebic liver abscess. This "tropical" parasite was described by F. Lösch from Russian patients living in the balmy latitudes approximately a hundred miles south of the Arctic Circle. Viruses are newer still. The first virus to be discovered was a virus not of humans but of plants. It was the tobacco mosaic virus described by the Russian D. Iwanowski, in 1892. The yellow fever virus, discovered in 1900 by the U.S. Army Commission led by Major Walter Reed, was the first viral disease of humans to be identified. *

"Reads like a murder mystery. . . . [Desowitz] writes with uncommon

Lucidity and verve, leaving the reader with a vivid understanding of malaria and other tropical diseases, and the ways in which culture, climate and politics have affected their spread and containment. "—New York Times

Why, Robert S. Desowitz asks, has biotechnical research on malaria produced so little when it had promised so much? An expert in tropical diseases, Desowitz searches for answers in this provocative book.

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