perform pediatric safety studies. It is because of the great success of these two programs that I am pleased that the bill requires both programs to be reauthorized together in 2012. This joint sunset date allows for further reauthorizations to continue balancing the incentives and authorities that drive pediatric study.

Most of all, I am pleased that the drug safety portion of the bill contains provisions from my Safer DATA Act. This language requires the FDA to establish and maintain an active surveillance infrastructure to collect and analyze drug safety data from disparate sources, such as: adverse events reports, Medicare Part D and VA health system data, and private health insurance claims data. The private sector and many academic institutions have had these capabilities for years. With this legislation, the FDA will finally have access to the best information possible.

The legislation also directs the FDA to establish drug safety collaborations with private and academic entities to perform advanced research and further analysis of drug safety data once the surveillance system detects a serious risk.

And finally, to enhance risk communication, the language establishes a one-stop shop web portal to give patients and providers better access to drug safety information, including aggregate information from the surveillance system.

I congratulate Senator KENNEDY and Senator ENZI for their support of the inclusion of this provision and for their efforts to get this bill finalized before the September 21 deadline.

We have consistently heard from HHS Secretary Leavitt and Commissioner Von Eschenbach over the past few months that if we failed to complete the reauthorizations of PDUFA and MDUFMA by September 21, they would be required to issue reduction-in-force—RIF—notices to FDA drug and device reviewers—the key staffers who are on the front lines of ensuring the safety and efficacy of FDA approved products. In 1997, when Congress failed to reauthorize PDUFA on time, the 1 month delay caused departures to the extent that it took 18 months for FDA to return to full staffing levels. Not only would the issuance of RIF notices this year have affected nearly 2,000 FDA employees and their families, but it would have essentially obliterated the ability of the agency to fulfill its public health mission.

So it may be surprising to some, that the key obstacle to finishing this bill over the last few weeks was the House Democratic leadership's insistence on a provision that they included on behalf of their most precious constituents—not the FDA employees, not the scientists, not even the patients, but the trial lawyers.

Yes, included deep in section 901 of this bill is a one-sentence rule of construction that makes the obvious statement that, notwithstanding the new authority granted to the FDA under this bill to require labeling changes; it is the responsibility of the drug company to comply with other regulatory requirements regarding the drug's label. This so called ''gift to the trial lawyers'' merely restates current law, and is not such a gift at all. Regardless of whether or not the drug company or the agency initiates a labeling change, it is the FDA that continues to have the express authority to approve, reject or modify the labeling of a drug.

Not only is this rule of construction meaningless, but it pales in comparison to the expansive authority given to the FDA throughout the rest of the bill's 422 pages. What this bill does at the majority's insistence is expand the reach of the FDA's regulatory authority over prescription drugs, devices, food, and even tanning beds.

In addition to the bill's many other provisions, section 901 gives the HHS Secretary explicit authority to request certain safety labeling changes. If the Secretary becomes aware of new safety information that the he or she believes should be included in the labeling for a drug, the Secretary may notify the drug company and begin a process to modify the label.

Under existing preemption principles, FDA approval of labeling under the Food, Drug, and Cosmetic Act preempts conflicting or contrary State law. The determination of whether or not labeling revisions are necessary is, in the end, squarely and solely the FDA's. Given the comprehensiveness of FDA regulation of drug safety, effectiveness and labeling under the Food, Drug, and Cosmetic Act, additional requirements for the disclosure of risk communication do not necessarily result in positive outcomes for patients, but create differing standards that heighten confusion.

If we had intended through this legislation to give State courts and State juries the authority to second guess the scientific expertise of the FDA, we would have done so. In fact, based on the totality of the bill's 422 pages we have done the opposite. The intent of this legislation is explicitly clear. One FDA. One gold standard. One expert Federal agency charged by Congress with ensuring that drugs are safe and effective and that product labeling is truthful and not misleading.

The PRESIDING OFFICER. The Senator from Indiana is recognized.

Mr. LUGAR. Madam President, I unanimous consent to speak as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

U.S. LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA ACT

Mr. LUGAR. Madam President, I rise today to discuss S. 1966, a bill that I introduced last month to reauthorize the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003—known as the Leadership Act. Under the Leadership Act, the American people have catalyzed the world's response to the HIV/AIDS epidemic. It is not often that we have an opportunity to save lives on such a massive scale. Yet every American can be proud that we have seized this opportunity. My message to Senators today is a simple one: let's agree that we should sustain this success, and let's move now to pass a reauthorization bill.

I believe that Congress should reauthorize the Leadership Act this year, rather than wait until it expires in September 2008. Partner governments and implementing organizations in the field have indicated that, without early reauthorization of the Leadership Act, they may not expand their programs in 2008 to meet the goals that we set for the President's Emergency Plan for AIDS Relief also known as PEPFAR. These goals include providing treatment for 2 million people, preventing 7 million new infections, and caring for 10 million AIDS victims, including orphans and vulnerable children.

Many partners in the fight against HIV/AIDS want to expand their programs. But to do so, they need assurances of a continued U.S. commitment beyond 2008. We may promise that a reauthorization of an undetermined funding level will happen eventually—but partners need to make plans now if they are to maximize their efforts. Today, they have only a Presidential proposal, not an enacted reauthorization bill. This is an important matter of perception, similar to consumer confidence. It may be intangible, but it will profoundly affect the behavior of individuals, groups, and governments engaged in the fight against HIV/AIDS.

I recently received a letter from the Ministers of Health of the 12 African focus countries receiving PEPFAR assistance. They wrote:

> Without an early and clear signal of the continuity of PEPFAR's support, we are concerned that partners might not move as quickly as possible to fill the resource gap that might be created. Therefore, services will not reach all those who need them. . . . The momentum will be much greater in 2008 if we know what to expect after 2008.

I realize that a PEPFAR reauthorization bill will face a crowded Senate calendar this year. But maintaining the momentum of PEPFAR during 2008 is a matter of life or death for many. Part of the original motivation behind PEPFAR was to use American leadership to leverage other resources in the global community and the private sector. The continuity of our efforts to combat this disease and the impact of our resources on the commitments of the rest of the world will be maximized if we act now.

Although the Leadership Act is an extensive piece of legislation, I believe that Congress can reach an agreement expeditiously on its reauthorization. Most of its provisions are sound and do

not require alteration. In fact, the act has provided for substantial flexibility of implementation that has been one of the keys to success of the PEPFAR program. The authorities in the original bill are expansive, and they are enabling the program to succeed in diverse nations, each with its own unique set of cultural, economic, and public health circumstances.

In developing S. 1966, I have consulted extensively with American officials who are implementing PEPFAR. Most believe that preserving the existing provisions of the Leadership Act would give them the best chance at continued success. Adding new restrictions to the law can limit the flexibility of those charged with implementation in 2009 and beyond. We don't know who that will be, and more importantly, we don't know what the challenges of 2013 will be—though we can probably say with confidence that the landscape will be very different then than it is today.

This is not to say that Senators may not have good ideas for improvement that should be adopted. But new provisions must not unduly limit the flexibility of the program, and Congress should avoid descending into time-consuming quarrels over provisions that are unnecessary or that have little to do with the core mission of the bill.

As Senators study the record of PEPFAR to date, I believe they will find that the vast majority of the authorities needed for the next phase of our effort already are in the existing legislation. I would like to outline how the existing legislation is dealing successfully with several specific areas of concern.

The first is Strengthening Health Systems. Some have expressed the view that additional authorities are needed to improve health systems in target countries. I agree that this area is a vital one if hard-hit nations are to have truly sustainable programs. Yet the current Leadership Act already contains ample authorities to help build health systems, and the United States is making extensive use of those authorities. To date, the emergency plan has supported nearly 1.7 million training and retraining encounters for health care workers and more than 25,000 service sites. In fiscal year 2007, PEPFAR estimates it will have invested nearly $640 million in network development, human resources, and local organizational capacity and training.

A recent study of PEPFAR treatment sites in four countries—Nigeria, Ethiopia, Uganda, and Vietnam—found that PEPFAR supported 92 percent of the investments in health infrastructure designed to provide comprehensive HIV treatment and associated care, including facility construction, lab equipment, and training. In these countries, PEPFAR also supported 57 percent of personnel costs and 92 percent of training costs.

In a separate study focused on Rwanda that examined 22 non-HIV/AIDS health indicators, 17 showed significant improvements as PEPFAR scaled up. Improvements in family planning and infant care, among other achievements, were deemed to have stemmed from ongoing HIV/AIDS programs. According to the chairman of the Institute of Medicine Committee, which recently completed a congressionally mandated study of the emergency plan:

> PEPFAR is contributing to make health systems stronger . . . doing good to the health systems overall.

In the Senate Foreign Relations Committee, we have paid particular attention to the devastating toll of HIV/AIDS on females. Women, and young girls in particular, are especially vulnerable to HIV and AIDS due to a combination of biological, cultural, economic, social, and legal factors. The Leadership Act's authorities in this area are robust. The emergency plan is already leading the world in incorporating gender considerations across its prevention, treatment, and care programs and addressing gender issues that contribute to the spread of HIV/AIDS. For example, in 2006, a total of $442 million supported more than 830 interventions that included one or more of the five priority gender strategies identified in the Leadership Act. These strategies include increasing gender equity in HIV/AIDS services, reducing violence and coercion, addressing male norms and behaviors, increasing women's legal protections, and increasing women's access to income and productive resources.

In Namibia, PEPFAR supports the Village Health Fund Project, a microcredit program that provides vulnerable populations, such as widows and grandmothers who care for orphaned grandchildren, with start-up capital for income-generating projects. In South Africa, PEPFAR supports a project that seeks to have men take more responsibility for preventing HIV infection and gender-based violence.

Another issue of special concern is food and nutrition. In 2004, I chaired a hearing of the Foreign Relations Committee on this subject that underscored how HIV/AIDS and hunger exacerbate each other in many African nations. The AIDS crisis has led to a food crisis for both its victims and their communities. It is no coincidence that the prevalence of HIV/AIDS is highest in countries where food is most scarce. PEPFAR has adopted guidance providing for the inclusion of nutritional assessment and counseling in care and treatment programs. It has also facilitated food support for targeted populations and assistance to long-term food security for orphans and vulnerable children. PEPFAR seeks to build on the comparative advantages of its partners in addressing food needs. These include USAID, the U.S. Department of Agriculture, and the United Nations World Food Program. These partners provide more direct support in food commodities and food security with a focus on overall communities. The PEPFAR approach of targeting individuals complements these efforts.

In Kenya, for example, PEPFAR is supporting a ''food by prescription'' approach and is working with the Kenyan government, the World Food Program and others to ensure that broader communities, as well as individuals who may fall outside of PEPFAR guidelines for support, are reached. In Haiti, PEPFAR works with partner organizations to support orphans and vulnerable children using a community-based approach. Children participate in a school nutrition program using USAID-title II resources. This program is also committed to developing sustainable sources of food. Thus, the program aggressively supports community gardens for children's consumption and for generating revenue through the marketing of vegetables.

On education, too, the Leadership Act's existing authorities are being put to productive use. In 2006, approximately $100 million in PEPFAR funding went toward programs that address barriers to school attendance for orphans and vulnerable children. This figure is expected to increase to $127 million in 2007. As it does with its nutrition programs, PEPFAR seeks to leverage its resources by ''wrapping around'' other programs that promote access to education, such as the President's African Education Initiative, or AEI.

For example, in Zambia, PEPFAR and AEI fund a scholarship program that helps nearly 4,000 orphans who have lost one or both parents to AIDS or who are HIV-positive stay in grades 10 through 12. Similar partnerships exist in Uganda, where PEPFAR and AEI are working together to strengthen life-skills and prevention curricula in schools. This program targets 4 million children and 5,000 teachers. Also in Uganda, through the AIDS Support Organization, PEPFAR helps almost 1,000 children by providing school fees and supplies for both primary and secondary school.

The emergency plan has dedicated nearly $191.5 million to pediatric treatment, prevention, and care during the last 2 years. The program has made steady progress, increasing the share of those receiving PEPFAR-supported treatment who are children from 3 percent in 2004 to 9 percent in 2006. The intent is to increase this figure to 15 percent.

PEPFAR has focused much effort on early identification of HIV-positive children. In many countries, an HIV test is used that cannot identify children as positive until they are 18 months old. Recognizing that 50 percent of HIV-positive children will die by age two if untreated, PEPFAR is working hard to introduce new diagnostic technology that can discern the HIV status of children at a much younger age.

Along with supporting treatment for children who are already infected, PEPFAR is devoting resources to ensuring that fewer children are infected

in the first place. To date, PEPFAR has dedicated more than $453 million to the prevention of mother-to-child transmission programs. In Botswana, Guyana, Namibia, Rwanda, and South Africa the percentage of pregnant women receiving mother-to-child transmission prevention services now exceeds 50 percent—the goal of the President's International Initiative to Prevent Mother and Child HIV. In the past few years, nearly all of the focus countries have adopted ''opt-out'' testing where pregnant women are given an HIV test during routine antenatal care unless they refuse the test.

Under the highly successful national program in Botswana, where approximately 14,000 HIV-infected women give birth annually, the country has increased the proportion of pregnant women being tested for HIV from 49 percent in 2002 to 96 percent in 2006. The number of infant infections has declined by approximately 80 percent, to a national transmission rate of less than four percent.

Although the authorities in the Leadership Act allow for an expansive array of activities, I am suggesting a few basic changes in this reauthorization. First, my proposal would increase to $30 billion the authorization for the years 2009 through 2013—a doubling of the initial U.S. commitment. Senators may wish to revisit this proposed funding level, and I look forward to that discussion.

I believe we need to keep the bill as free of funding directives as possible to ensure maximum flexibility for implementation. This was recommended by the Institute of Medicine. I am proposing that only two funding directives be included—one modified from its current form, the other maintained as it is.

The first modification would seek to address the abstinence directive in current law. The administration has interpreted and implemented this provision so as to include both abstinence and faithfulness programs, the 'AB' of 'ABC,' which stands for Abstinence, Be faithful, and the correct and consistent use of Condoms. The ABC paradigm for prevention was developed in Africa by Africans, to address the wide range of risks faced by people within their nations. Recent evidence from a growing number of African countries shows a correlation between declining HIV prevalence and the adoption of all three of the ABC behaviors. PEPFAR implements a program that teaches young children to respect themselves and others. Part of that respect is to refrain from sexual activity and to be faithful to a single partner. As children grow older, they learn about other ways to protect themselves so that they have the information and tools they need to live healthy lives. These are not revolutionary concepts. Rather they are commonsense approaches to public health based on broad experience garnered from many cases and studies.

The problem with this directive, however, is that it has applied to all prevention funding—not just to funding for prevention of sexual transmission. This has had the effect of squeezing funding for prevention activities that have nothing to do with sexual prevention—such as prevention of mother-to-child transmission and blood transfusion safety. The language I propose would address this by applying the directive only to funding for prevention of sexual transmission, rather than to prevention funding as a whole. This will enable greater flexibility.

At the same time, the language would ensure the continuation of funding for abstinence and faithfulness programs as part of comprehensive, evidence-based ABC activities. Rather than maintaining the existing directive of 33 percent of all prevention funding, the proposal would require that 50 percent of the sexual prevention subset of prevention activities be spent to support abstinence and faithfulness. It also acknowledges that different strategies are needed depending on the facts of the epidemic in each country—something PEPFAR is already doing. I think this compromise approach is one that can win support from across the political spectrum and provide increased flexibility while ensuring continued support for comprehensive, evidence-based prevention. I look forward to working on this with my colleagues.

The one directive in the Leadership Act that I believe must be maintained holds that 10 percent of funding be devoted to programs for orphans and vulnerable children. There were few programs focused on the needs of these children before the Leadership Act, and we remain in the early stages of the effort to serve them. Before the advent of PEPFAR, neither the United States, nor anyone else, had much experience in programs to support children infected with, or affected by, HIV/AIDS. After several years of effort, we have made some progress, but our programs are not yet as firmly established as they can be. This year PEFPAR invited proposals for orphans programs from the field—but the number of proposals that came back was far less than the available funding. This indicates that we still have much work to do in this area, and maintaining this directive will help to ensure that we do it.

The AIDS orphans crisis in sub-Saharan Africa has implications for political stability, development, and human welfare that extend far beyond the region. The American people strongly back this effort, and the maintenance of this directive will help to ensure that we remain attentive to those who need our support the most. The directive will also help ensure the success of the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, a bill I drafted, which was cosponsored by 11 Senators. That bill was signed into law on November 8, 2005.

My bill also includes some new language regarding the Global Fund, an organization that enjoys wide support in Congress. The Global Fund is a critically important partner in our fight against HIV/AIDS. In addition to our contributions, we are active on its board, and U.S. personnel provide the Global Fund with extensive technical assistance. The Global Fund is an avenue for the rest of the world to make contributions to antidisease initiatives. The United States is the largest supporter of the Global Fund, having provided more than $2 billion so far. The American people have contributed approximately one-third of all moneys received by the fund.

The fund is subject to pressures from many donors, and it is widely acknowledged that it would benefit from greater transparency and accountability. As chairman of the Senate Foreign Relations Committee from 2003 through 2006, I oversaw the passage of legislation that strengthened the transparency and accountability of international organizations that receive U.S. funding, including the World Bank and the International Monetary Fund. My proposed language would establish similar benchmarks for U.S. funding for the Global Fund. I address such benchmarks at some length in my proposed legislation—not because of concerns over specific Global Fund activities—but rather to ensure sound practices and give members confidence that U.S. contributions are being monitored carefully. Most of these benchmarks are based on provisions contained in past appropriations bills, and I do not believe they will be controversial.

S. 1966 would maintain the limitation in the existing Leadership Act that U.S. contributions to the Global Fund may not exceed 33 percent of its funding from all sources. This limitation has proven to be a valuable tool for increasing contributions to the fund from other funding sources, including other governments, and I believe there is wide agreement that this provision should be maintained.

Lastly, let me turn from the details of the proposed legislation to add some perspective to this reauthorization effort. The U.S. National Intelligence Council and innumerable top officials, including President Bush, have stated that the HIV/AIDS pandemic is a threat to national and international security.

The pandemic is rending the socioeconomic fabric of communities, nations, and an entire continent, creating a potential breeding ground for instability and terrorism. Communities are being hobbled by the disability and loss of consumers and workers at the peak of their productive, reproductive, and care-giving years. In the most heavily affected areas, communities are losing a whole generation of parents, teachers, laborers, health care workers, peacekeepers, and police.

United Nations projections indicate that by 2020, HIV/AIDS will have depressed GDP by more than 20 percent in the hardest-hit countries. The World

Bank recently warned that, while the global economy is expected to more than double over the next 25 years, Africa is at risk of being ''left behind.''

Many children who have lost parents to HIV/AIDS are left entirely on their own, leading to an epidemic of orphan-headed households. When they drop out of school to fend for themselves and their siblings, they lose the potential for economic empowerment that an education can provide. Alone and desperate, they sometimes resort to transactional sex or prostitution to survive, and risk becoming infected with HIV themselves.

I believe that in addition to our own national security concerns, we have a humanitarian duty to take action. Five years ago, HIV was a death sentence for most individuals in the developing world who contracted the disease. Now there is hope. We should never forget that behind each number is a person—a life the United States can touch or even save.

At the time the Leadership Act was announced, only 50,000 people in all of sub-Saharan Africa were receiving antiretroviral treatment. Through March of this year, the act has supported treatment for more than 1.1 million men, women, and children in 15 PEPFAR focus countries. During the first three and a half years of the act, U.S. bilateral programs have supported services for more than 6 million pregnancies. In more than 533,000 of those pregnancies, the women were found to be HIV-positive and received antiretroviral drugs, preventing an estimated 101,000 infant infections through March 2007.

Before the advent of PEPFAR, there was little concerted effort to meet the needs of those orphaned by AIDS, or of other children made vulnerable by it. We have now supported care for more than 2 million orphans and vulnerable children, as well as 2.5 million people living with HIV/AIDS, through September 2006.

Effective prevention, treatment, and care depend to a large extent on people knowing their HIV status, so they can take the necessary steps to stay healthy. The United States has supported 18.7 million HIV counseling and testing sessions for men, women and children.

Our financial investment in this fight has been critical to our success, and thanks in large part to the flexibility of the Leadership Act, we have been able to obligate more than 94 percent of its available $12.3 billion appropriated through this fiscal year.

PEPFAR, led by its coordinator, Ambassador Mark Dybul, has utilized the existing Leadership Act authorities well and has listened to the Congress and many other stakeholders. We should maintain the flexibility to respond to the changing dynamics of the epidemic, rather than locking in particular approaches that might be appropriate for 2007, but that might prove problematic for future years. As the Institute of Medicine said, the Global Leadership Act is a ''learning organization.'' We should pass a bill now that allows PEPFAR to expand and evolve its program implementation utilizing the experience of these past 3½ years.

I believe that we will save more lives and prevent more infections if we reauthorize this remarkable program this year. I ask my colleagues to work with me to achieve a truly bipartisan triumph of which we can all be proud.

I thank the Chair, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. REID. Madam President, I ask unanimous consent that the Senate now proceed to a period for the transaction of morning business, with Senators allowed to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DORGAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CASEY). Without objection, it is so ordered.

IRAQ

Mr. DORGAN. Mr. President, I am going to make a few comments this morning about a hearing we just completed in the Democratic policy committee, but I am waiting for some charts. While I am waiting for those charts, I want to talk a moment about what is happening with respect to the debate here in this Chamber dealing with the war in Iraq. It relates to some things I said on the floor of the Senate yesterday but I think really bear repeating.

We are talking about the war in Iraq, the need to attempt to change course in Iraq, and yesterday I described again what the latest National Intelligence Estimate tells us. Now, all of us have access to this. There is a classified version, a top-secret version, and a nonclassified version, but all of us have access to this information. Here is what it says in the context of protecting this country and providing security and safety for this country. Here is what the National Intelligence Estimate says:

Al-Qaida is and will remain the most serious terrorist threat to the homeland. We assess the group has protected or regenerated key elements of its homeland attack capability, including: a safe haven in the Pakistan federally administered tribal areas, operational lieutenants, and its top leadership.

Here is what it says. It says the greatest terrorist threat to our homeland is al-Qaida and its leadership, who even now are plotting attacks against our country and who have a safe haven in the Pakistan region. Now, if that is the case, it is quite clear that the central fight on terrorism is not going door to door in Baghdad in the middle of a civil war. Yet that is what we are doing.

I have asked this question, and I have repeatedly asked it: Why should there be 1 square inch on the planet Earth that is secure or safe for Osama bin Laden and the leadership of al-Qaida? Yet our National Intelligence Estimate says they are in a safe haven. A ''safe haven.'' These are the people who boasted of killing Americans on 9/11. They boasted about engineering 19 terrorists aboard airplanes full of fuel and passengers, and they ran them into buildings, killing innocent Americans. And 6 years later, our National Intelligence Estimate tells us that those who engineered that attack have regrouped, are developing new training camps for terrorists, and are in a safe haven and developing new plans to attack America. That is unbelievable to me.

We are debating the war in Iraq, which our National Intelligence Estimate also says is largely sectarian violence, or a civil war. Yes, there is some al-Qaida in Iraq, but that is not the central front, and that is not the central war on terrorism. If, in fact, our role as a responsible country is to protect our citizens, then it seems to me we would change course and change strategy so that we are taking the fight to the terrorists and fighting the terrorists first.

We have been bogged down—longer now than in the Second World War—in what has become a civil war in Iraq. Meanwhile, the greatest terrorist threat to our homeland is in a safe haven. Osama bin Laden, al-Zawahiri, and others, the leadership of al-Qaida, in a safe haven.

What are the consequences of that safe haven? Let me show a newspaper report from last week. All of us understand this because we heard about it. They picked up terrorists in Denmark, they picked up terrorists in Germany. The terrorists in Germany were plotting attacks against the largest U.S. military base in Europe. Where did those terrorists train? In Pakistan. In terrorist training camps in Pakistan.

We are now seeing the fruit of what has been allowed to happen—the leadership of al-Qaida in a safe or secure place, operating or developing new training camps, training new terrorists to launch attacks against our country. Meanwhile, we are going door to door in Baghdad in the middle of sectarian