

that a “fitting and proper” commemoration is planned. I am pleased to report that a number of our goals have already been met—the authorization of new penny designs in the bicentennial year and the issuance of a commemorative coin, for example. Other educational, scholarly, cultural, and historical events are in various stages of planning—both here in the United States and abroad.

After President Lincoln’s untimely death, Edwin M. Stanton said, “Now he belongs to the ages.” Mr. President, today we remember Abraham Lincoln’s service in the House, his leadership during our Nation’s most perilous time, and his legacy of freedom, democracy, and equal opportunity. Even great life begins with a series of small but important steps. Let us keep working to carry out Abraham Lincoln’s vision in our day.

AFRICAN HEALTH CAPACITY INVESTMENT ACT

Mr. DURBIN. Mr. President, this week I introduced the African Health Capacity Investment Act of 2006.

This bill was inspired last December, when I visited the Democratic Republic of Congo with Senator SAM BROWNBACK of Kansas.

The Congo is one of the poorest, most violent regions on Earth. This past weekend, it held its first multiparty elections in nearly 50 years. That is a moment to celebrate.

But one of the most profound challenges that the newly elected government will face is how to even begin to meet the health needs of its people. In the DRC, there are only 7 doctors and 44 nurses per 100,000 people. In the eastern Congo, which has witnessed terrible conflict and disease, there is only 1 doctor per 160,000 people. And, I was told, in the city of Goma, surgeons are literally one in a million. To put that in perspective, imagine three surgeons in a city the size of Chicago. Imagine living like that, and then imagine your doctors and nurses leaving for countries with better working conditions, better pay, and brighter futures.

That is the situation that the Congo and almost all of Sub-Saharan Africa faces every day, as doctors and nurses leave rural areas for African cities and leave African cities for the United States, the United Kingdom, and other Western destinations. Every year, Africa loses another 20,000 trained health professionals to European and North American medical facilities. That is an enormous brain drain.

As Randall Tobias, the U.S. Director of Foreign Assistance, has noted, there are more Ethiopian-trained doctors practicing in Chicago than in Ethiopia.

In the United States, we have 549 doctors and 773 nurses for every 100,000 people. And even at those levels, we face our own personnel shortages. As the baby boomers age and our health workforce retires, our shortages will grow. It has become our habit to recruit doctors and nurses from abroad

and increasingly from the developing world to staff our hospitals, doctors’ offices, and other health centers.

Those individuals immigrate here for the same reasons that people have always migrated here. They come for economic opportunities, greater freedom, and a better future for their children. As the son of an immigrant, I recognize their motivations and welcome the contributions that they make. But I also have to look at the countries that they leave behind.

That is what struck me so powerfully in the Congo: that we cannot continue to depend on the poorest countries in the world to train our doctors and nurses. We have to expand our own health workforce. Our nursing schools turn away thousands of qualified applicants every year because they don’t have enough faculty to teach them. We have to fix that.

And we have to help Africa heal itself because even if the brain drain stopped completely, even if every doctor and nurse on the continent of Africa stayed there, they would still have tremendous shortages of health personnel.

That is why Senators COLEMAN, DEWINE, and FEINGOLD and I introduced the African Health Capacity Act this week.

The World Health Report concluded in 2003, “The most critical issue facing health care systems is the shortage of people who make them work.” The 2006 report, which focused entirely on health workforces, helped provide a blueprint on how to build that critical human infrastructure.

Sub-Saharan Africa has 11 percent of the world’s population. It bears 25 percent of the global disease burden. But it has only 3 percent of the world’s health workers, and it suffers nearly half of the world’s deaths from infectious diseases.

Personnel shortages are a global problem, but nowhere are these shortages more extreme, the infrastructure more limited, and the health challenges graver than in Sub-Saharan Africa, the epicenter of the HIV/AIDS pandemic. We will not win the war against AIDS or any other health challenge without finding solutions to this problem. It looms larger than shortages of ARVs or any other single factor. The Institute of Medicine has called the health care worker shortage the greatest obstacle to fighting HIV/AIDS.

AIDS has had a particularly insidious effect on health workforces in Africa. Beginning in the 1980s, HIV/AIDS began to take a terrible toll among health workers in Africa. In 2000, 20 percent of the student nurses in Mozambique died from AIDS. Health workers are particularly vulnerable because many lack access to gloves or training in universal precautions that would help protect them from infection. These unsafe working conditions naturally drive many people to seek either safer jobs or employment in other countries. As illness, death, and migration reduce staff, those who are left face even heav-

ier workloads, and they too may leave. This is a deadly and vicious cycle that we have to help Africa break.

The shortage of personnel has deadly repercussions that extend far beyond HIV/AIDS. A woman in Sub-Saharan Africa, for example, has a 1 in 13 chance of dying in pregnancy or childbirth, according to UNICEF. In resource-rich countries such as ours, that risk is 1 out of 4100. You change those terrible odds for the woman in Africa by providing greater access to skilled birth attendants. You greatly improve the newborn baby’s chance at survival as well.

It is critically important that as we increase assistance for HIV/AIDS and for health and economic development more generally, that we work to strengthen health systems as a whole. The Office of the Global AIDS Coordinator is doing terrific work at boosting health capacity in the public and private sectors, and USAID has also been engaged in this effort.

This bill is intended to give these agencies the tools to do more and to better integrate and coordinate their activities.

The bill seeks to help Sub-Saharan African countries strengthen the capabilities of their health systems by helping countries improve dangerous and Sub-standard working conditions; helping them train, recruit, and retain doctors, nurses, and paraprofessionals; developing better management and public health training; and improving productivity and workforce distribution. Collecting workforce data, or strengthening the public health sector may not sound very glamorous, but steps like these are critical to creating the health infrastructure that Africa so badly needs.

That infrastructure may also be very important to us. With air travel to spread avian flu, scientists tell us that we may have only 3 weeks to contain an outbreak of the disease from the time that outbreak is detected anywhere in the world. If we miss that window, the outbreak of avian flu may become a pandemic and spread around the world.

As stated in the Harvard Public Health Review, “Those regions of the world where human expertise and resources are in shortest supply, such as Africa, are most likely to serve as particularly fertile ground for getting a large-scale human flu epidemic off to a robust start.” It is in our own interests, as well as Africa’s, to improve its public health infrastructure.

This same point was made in the President’s 2002 National Security Strategy. This document provides the administration’s fundamental view of how we should confront global challenges and opportunities in the security arena. It is a measure of risks and priorities that is issued each Presidential term.

President Bush’s 2002 National Security Strategy stated, “The scale of the

public health crisis in poor countries is enormous. In countries afflicted by epidemics and pandemics like HIV/AIDS, malaria, and tuberculosis, growth and development will be threatened until these scourges can be contained. Resources from the developed world are necessary but will be effective only with honest governance, which supports prevention programs and provides effective local infrastructure.”

This bill is not just about spending more money to build African health capacity. It is also about spending that money better. This bill authorizes assistance to improve management and reduce corruption within the health sector. It requires the President to establish a monitoring and evaluation system to measure the effectiveness of our assistance.

Knowledge sharing is also important: Each minister of health and each non-governmental organization should not have to reinvent the wheel.

Two years after enactment, this bill will require the production of a document publicizing best practices. This clearinghouse of information will provide valuable help for developing countries throughout the world.

The United States provides billions of dollars to fight HIV/AIDS, malaria, TB, and other health challenges in Africa. It is critical, as we pursue these programs, that we better integrate them within a framework to strengthen health systems as a whole. We need to help countries better invest their own human and material resources as well as our assistance.

In 2005, 2 million people in Sub-Saharan Africa died of AIDS, and 2.7 million people became newly infected. Nearly a million African children under the age of 5 died of malaria. Hundreds of thousands of Africans died last year of TB, cholera, dysentery, and other infectious diseases or in childbirth. These devastating mortality rates also strangle opportunities for economic development. But we can begin to change those trajectories by investing in African health capacity. Imagine living in a country like Ethiopia, with 3 doctors for every 100,000 people. Then ask yourself what we can do about it. This bill is a start.

I thank my colleagues, Senators COLEMAN, DEWINE, and FEINGOLD, for joining me in introducing this bipartisan bill, and I hope others will join us.

DETAINEE TREATMENT ACT

Mr. GRAHAM. Mr. President, I rise today to correct the public record with regard to a matter raised by the U.S. Supreme Court's decision in *Hamdan v. Rumsfeld*, 126 S.Ct. 2749 (2006). In part II of its opinion, the majority in *Hamdan* addressed whether the Detainee Treatment Act barred *Hamdan's* lawsuit from proceeding in its then-present form. As the court noted, the DTA provides that “no court, justice, or judge shall have jurisdiction to hear or con-

sider” claims filed by Guantanamo detainees, except under the review standards created by that act.

In the course of drafting the DTA conference language regarding jurisdiction, Senator KYL, myself, and several others we consulted, specifically relied on the Bruner line of cases for guidance. In that line of cases, we had taken particular note of Justice Stevens's opinion in *Landgraf*, where, in discussing the Bruner line, he wrote that the Court had a consistent practice of ordering an action dismissed when the jurisdictional statute under which that action had been filed was subsequently repealed. Since that was precisely what we were doing in the DTA, reversing the *Rasul* finding of jurisdiction through the habeas statute, we were very comfortable with how our language addressed the jurisdictional change.

Likewise, the Bruner/*Landgraf* line of cases informed the enactment language regarding the substantive law changes we were making. Because of Justice Stevens's explanation in *Landgraf*, we felt we had to make those provisions specifically apply to pending cases. However, for everything else, including the requirements for the executive branch to do certain things within certain time periods, having a single enactment statement saying everything applied retroactively did not make sense. So, with that and other concerns, we ended up with what emerged from the conference process between passage of the amendment in November and adoption of the conference product in December. It was complicated and merged a number of concepts.

You see, as the author of that part of the Detainee Treatment Act, it was never my intent to carve out pending cases from the effect of that act. As I have detailed above, we knew the governing law and expected the courts to apply it. And I never hid this intent or understanding. My statements regarding this intent were consistent from the beginning of the debate on November amendment until final passage of the conference report on December 21. This is why I issued a joint statement with Senator LEVIN in early January of this year which stated, “[t]he intent of the language contained within the Graham-Levin-Kyl amendment is that Courts will decide in accord with their own rules, procedures and precedents whether to proceed in pending cases.”

In reviewing the record, Justice Scalia and the other dissenters recognized this consistency. Justice Scalia stated that, “[s]ome of the statements of Senator GRAHAM, a sponsor of the bill, only make sense on the assumption that pending cases are covered.” Thus, they correctly concluded that the jurisdictional removal language included all pending cases.

Indeed, when the final version of the DTA passed the Senate, I and some of the cosponsors of my November amendment included a colloquy in the RECORD in which we made clear that we were perfectly aware of the Supreme

Court's previous holdings governing jurisdiction-removing statutes and that we had not chosen the language of the amendment by accident. We had initially intended to explain our provisions of the DTA on the floor, but with time growing short, and rather than forcing our colleagues to listen as we droned on, we dropped the statement into the RECORD and everyone went home for the Christmas break.

The Hamdan majority addressed this statement in footnote 10 of its opinion. First, the Court noted that on November 15, “Senator LEVIN urged adoption of an alternative amendment [the final version of my amendment] that ‘would apply only to new habeas cases filed after the date of enactment.’” The Court then dismissed my own statement of views in the following passage:

While statements attributed to the final bill's two other sponsors, Senators Graham and Kyl, arguably contradict Senator Levin's contention that the final version of the Act preserved jurisdiction over pending habeas cases, see 151 Cong. Rec. S14263–S14264 (Dec. 21, 2005), those statements appear to have been inserted into the Congressional Record after the Senate debate. See Reply Brief for Petitioner 5, n. 6; see also 151 Cong. Rec. S14260 (statement of Sen. Kyl) (“I would like to say a few words about the *now-completed* National Defense Authorization Act for fiscal year 2006” (emphasis added)). All statements made during the debate itself support Senator Levin's understanding that the final text of the DTA would not render subsection (e)(1) applicable to pending cases. See, e.g., *id.*, at S14245, S14252–S14253, S14274–S14275 (Dec. 21, 2005).

There are three misstatements of fact in footnote 10 of *Hamdan* that I would like to publicly correct. First, the colloquy that Senator KYL and I submitted for the RECORD was not submitted after the Senate's consideration of the bill. It was submitted well before the final vote on the conference report, and was necessary due to the substantial changes we made between the adoption on the amendment on November 15 and the adoption of the conference report on December 21.

Second, I have had a member of my staff view the tapes of the Senate's deliberations on November 15 that were prepared by the Senate Recording Studio. These tapes confirm that the statement from Senator LEVIN that the Supreme Court quoted from that day was not made live, but instead appears to have been submitted for the RECORD.

And third, my staff has viewed the tapes of the Senate's deliberations on December 21. These tapes confirm that the statements to which the Supreme Court cites from that day, statements by Senators LEAHY, DURBIN, and FEINGOLD, also were not spoken live on the Senate floor but were instead submitted for the RECORD. As I will discuss later, it generally doesn't matter to me if a statement is live or not, but it does bear noting the distinction given the Court's focus on it in this case.

The Supreme Court appears to have been misled about the nature of the