



## **ENVIRONMENTAL JUSTICE MUST INCLUDE ENVIRONMENTAL ACCESSIBILITY**

**Multiple Chemical Sensitivity (MCS):  
Address Existing Harm and Prevent Future Harm**

Submission on Canada's Draft National Strategy Respecting Environmental Racism and  
Environmental Justice 2026–2031

**Submitted by  
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**“Equal access to a healthy  
environment must include the ability  
to access that environment.”**



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## Executive Summary

We welcome Canada's first draft National Strategy Respecting Environmental Racism and Environmental Justice 2026–2031. The draft establishes an important national framework grounded in procedural, recognition, distributive and restorative justice, and calls for the removal of barriers to participation, attention to intersectionality, stronger data and meaningful engagement with affected communities.

We respectfully identify a significant gap: Multiple Chemical Sensitivity (MCS) and environmental accessibility are not yet adequately visible in the Strategy. This matters because environmental justice is not only about where pollution sources are located. It is also about routine and cumulative exposures, the unequal ability to avoid or recover from harmful exposures, and whether environmental conditions themselves prevent people with disabilities from accessing healthcare, housing, employment, education and public life.

### **Environmental justice carries two obligations: ADDRESS EXISTING HARM and PREVENT FUTURE HARM.**

Where environmental conditions have already contributed to harm, justice requires recognition, healthcare, protection, accessibility, accommodation and meaningful participation for people already harmed. At the same time, justice requires action to prevent avoidable harm to others. **Addressing existing harm without prevention allows avoidable harm to continue. Prevention without addressing existing harm leaves those already harmed behind. Environmental justice requires both.**

### Why MCS requires attention now

| Evidence                                                                                                      | Why it matters for environmental justice                                                                           |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| 9.4% of Canadian adults reported MCS in preliminary January–July 2025 CCHS data — about 3.104 million adults. | Approximately one in ten adults: this is not a marginal population.                                                |
| 12.8% of adult women reported MCS — about 2.138 million women.                                                | Approximately one in eight women: sex-based disparity must be visible in environmental and disability policy.      |
| 2.7% reported diagnosed MCS — about 900,100 adults.                                                           | The gap between reporting and diagnosis raises questions about recognition and access to knowledgeable healthcare. |
| Diagnosed MCS rose from 1.9% (475,972 people) in 2000–2001 to 3.5% (1,130,801 people) in 2020.                | Long-term Canadian surveillance documents a substantial diagnosed population and a rising trend through 2020.      |



|                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| In 2020, 72.1% of Canadians with diagnosed MCS were women.                                                                                                                                                                                    | Environmental justice analysis should examine sex/gender and disability together.                                                                                                                                                                                                                                                                                         |
| Among adults with diagnosed MCS in preliminary 2025 data, 41.3% reported that symptoms first appeared before age 25. A further 34.7% reported onset between ages 25 and 44. Together, 76.0% reported that their symptoms began before age 45. | For the first time, national data reveal that MCS symptoms often begin much earlier in life than previous age-prevalence data could show, with implications for prevention, healthcare, education, employment and cumulative socioeconomic disadvantage.<br><br>Excluding children and youth from contemporary surveillance can obscure early onset and prevention needs. |
| Previous Canadian analysis estimated more than \$25 billion annually in potential lost earned income associated with diagnosed MCS and non-participation in employment.                                                                       | The economic cost of exclusion may be substantial, even before healthcare, disability supports, absenteeism, lost tax revenue and other societal costs are considered.                                                                                                                                                                                                    |

Note: The 2025 figures are preliminary January–July estimates for Canada excluding the territories and for adults aged 18+. They should not be treated as directly comparable with earlier CCHS cycles without accounting for differences in scope and measurement.

## Our principal request

The final Strategy should explicitly identify people living with MCS among populations vulnerable to environmental harm and should incorporate environmental accessibility as a core environmental justice consideration. It should establish concrete federal actions spanning environmental protection, chemical and product policy, indoor air, disability and accessibility, healthcare, housing, employment, research and population surveillance.

## 1. A Missing Environmental Justice Population

The draft Strategy recognizes that environmental hazards intersect with systemic inequities and that environmental justice requires more than a narrow pollution-source analysis. Its own study considered whether environmental risk should be understood through specific events, routine exposure to environmental hazards, or measured exposure to particular chemicals. For the national mapping exercise, however, the analytical approach ultimately emphasized industrial pollution sites, federal contaminated sites and federally regulated wastewater sources.

That is an understandable starting point, but it leaves a major category of environmental experience underdeveloped: exposure occurring in the places where people spend most of their lives — homes, workplaces, healthcare settings, schools, public buildings and transportation — through consumer



products, cleaning and maintenance products, fragrances, building materials, renovations, pesticides and other indoor sources.

For people with MCS, these exposures can function as disability barriers. An environment may comply with a population-based guideline and still be inaccessible to a person whose functional capacity is affected by chemical exposures. Environmental justice therefore needs an accessibility lens in addition to a conventional toxicological and geographic lens.

**A healthy environment is not equitably available if a person cannot safely enter it, remain in it, or use the services located within it.**

## 2. Scale, Sex Disparity and the Cost of Being Left Out

Canadian evidence now makes the scale difficult to ignore. Peer-reviewed analysis of Statistics Canada's Canadian Community Health Survey documented diagnosed MCS increasing from 1.9% in 2000–2001 to 3.5% in 2020, representing more than 1.13 million Canadians in 2020. Women represented 72.1% of the diagnosed MCS population in 2020.

Preliminary January–July 2025 CCHS supplementary data provide a different and broader measure: 9.4% of adults reported having MCS, representing approximately 3.104 million adults, while 2.7% reported diagnosed MCS, approximately 900,100 adults. Among women, 12.8% reported MCS — approximately one in eight adult women — compared with 5.9% of men.

New 2025 Statistics Canada data provide an important new insight into the age at which MCS symptoms begin. For the first time, respondents with diagnosed MCS were asked when their symptoms first appeared. The largest group — 41.3%, representing approximately 363,700 Canadian adults — reported that their symptoms appeared before age 25. A further 34.7% reported onset between ages 25 and 44. Together, 76.0% reported that their symptoms began before age 45.

This finding adds an important new dimension to earlier Statistics Canada data. Previous surveys reported the current age of people living with diagnosed MCS and showed substantial representation among middle-aged and older adults, but they did not tell us when MCS symptoms first began. The 2025 data now reveal that, for many Canadians with diagnosed MCS, symptoms began much earlier in life than previous age-prevalence data could show. This has important implications for prevention, early recognition, healthcare, education and employment, and for understanding the potential cumulative social and economic consequences of MCS across the life course.

These figures should not be used to claim a simple increase from the 2020 diagnosed estimate to the 2025 self-reported estimate; the measures and survey scope differ. They do, however, establish two important realities: Canada has documented a substantial diagnosed MCS population over decades, and contemporary survey data indicate a much larger population reporting MCS than is captured by diagnosis alone.

The disproportionate burden among women deserves explicit analysis. Environmental exclusion can remove people from paid employment, but its effects extend further: family life, caregiving, education,



creativity, community leadership and civic participation can all be constrained when ordinary environments are inaccessible. A Strategy committed to intersectionality and Gender-Based Analysis Plus should not allow a condition reported by approximately one in eight adult women to remain invisible.

### 3. Environmental Exposure Can Become Socioeconomic Exclusion

CCHS analyses from 2015–2016 show that people with MCS experience substantial socioeconomic disadvantage despite meaningful educational attainment. Approximately 40% of people with MCS were not working, compared with about 24% of the general population. A substantial share of people with MCS who were not working nevertheless had post-secondary or university education, indicating that lower labour-force participation cannot be explained simply by lack of education.

Income patterns tell a similar story. Approximately 65% of people with MCS had personal annual income below \$40,000, and approximately 38% had income below \$20,000 in the 2015–2016 analyses. Housing indicators also point to vulnerability: people with MCS were more likely to rent and more likely to live alone than people without MCS.

The economic consequences extend far beyond individual hardship. Based on the estimated number of Canadians with diagnosed MCS who were not working and an average Canadian annual personal income of approximately \$56,000, previous ASEQ-EHAQ analysis estimated more than \$25 billion annually in potential lost earned income alone. This estimate is illustrative rather than a comprehensive cost-of-illness calculation, but its scale is significant. It does not include lost tax revenues, disability and income-support expenditures, healthcare costs, absenteeism, presenteeism and reduced productivity, informal caregiving, or the economic value of lost participation in unpaid work and community life.

Importantly, that estimate predates the preliminary 2025 Statistics Canada finding that approximately 3.104 million Canadian adults (9.4%) report MCS. Canada has not yet calculated the full economic burden associated with this much larger population. The emerging socioeconomic analysis reinforces the need for a comprehensive Canadian economic-burden assessment. People with MCS were substantially less likely to be working even at comparable levels of education, and among those working, 16.5% reported missing work because of a chronic condition during the preceding three months, compared with 5.9% of people without MCS — nearly three times the proportion.

The question for government is therefore not only what it will cost to make workplaces, healthcare, housing and public environments more accessible. It is also what Canada is already paying for failing to do so. Prevention and accessibility are investments in keeping Canadians healthy, employed, economically independent and participating in society.

Recent peer-reviewed Canadian research further documents the connection between disability recognition, accommodation and socioeconomic exclusion. Diallo et al. (2026b) identified accommodation refusals and socioeconomic challenges among Canadians with MCS, demonstrating



how failures of recognition and accommodation can compound barriers to employment, healthcare, housing and participation in society.

These are not merely economic statistics. They describe what happens when environmental barriers intersect with disability recognition, healthcare access, accommodation and housing availability. A person may have education and skills yet be unable to remain in a fragranced workplace; may require housing with lower-emission materials yet have fewer financial choices; or may need healthcare while the healthcare environment itself presents an exposure barrier.

## **4. Address Existing Harm: Recognition, Healthcare, Housing and Accessibility**

Restorative justice, as described in the draft Strategy, requires attention to people who have already experienced harm. For MCS, this means that prevention alone is insufficient. People living with MCS now require practical pathways to healthcare, accessible environments, accommodation and participation.

CCHS analyses of unmet healthcare needs among people with MCS identify barriers including services being unavailable in the area, treatment cost, lack of a regular healthcare provider and transportation. Community-based research has also documented avoidance of healthcare and difficulty obtaining accommodation when chemical and fragranced exposures are present.

The mismatch between population need and clinical capacity is stark. In 2020, more than 1.13 million Canadians had diagnosed MCS. More than 400,000 lived in Ontario, yet Ontario has only one publicly funded environmental health clinic providing specialized assessment and care for MCS, the Environmental Health Clinic at Women's College Hospital. According to a physician at the Clinic, it operates with approximately 0.8 full-time-equivalent funded physician capacity. Patients may face long waits (up to 3 years), travel significant distances for assessment, and often arrive after years of seeking answers and seeing multiple specialists.

Québec presents an equally concerning gap. More than 250,000 Québec residents had diagnosed MCS in 2020, yet, to the knowledge and direct service experience of ASEQ-EHAQ, Québec has no dedicated publicly funded clinical service providing specialized assessment, management and continuing care for people with MCS. ASEQ-EHAQ regularly assists people seeking knowledgeable healthcare for MCS and has witnessed the consequences of this absence of clinical infrastructure. Limited access to diagnosis without a corresponding pathway to knowledgeable management and continuing care does not meet the healthcare needs of this population.

The urgency is even greater in light of preliminary 2025 Statistics Canada findings that approximately 3.104 million Canadian adults now report MCS. Canada does not presently know the full healthcare needs represented within this population. People with MCS should have access to knowledgeable healthcare across the continuum of need, including timely recognition and assessment, appropriate treatment and management, and specialized care where required. Understanding these healthcare needs — and building the clinical capacity to meet them — should be a national priority.



Canada should urgently build clinical capacity for MCS. Training should draw on physicians and other healthcare professionals with substantial experience caring for people with MCS in Canada and internationally, while building a rigorous evidence base for diagnosis, treatment and management. People currently living with MCS should not have to wait for the completion of future research before receiving knowledgeable, respectful and accessible healthcare.

Healthcare facilities should implement effective source-control practices, lowest-emission product selection and fragrance-free approaches that allow people with MCS to obtain care without encountering avoidable environmental barriers.

Housing must be treated as an environmental justice and accessibility issue. Advice to 'avoid exposure' is not meaningful if a person cannot obtain suitable housing. Federal housing programs and guidance should incorporate healthy, lowest-VOC, least-toxic, fragrance-free approaches to materials, renovations, cleaning, pest management and maintenance, with particular attention to low-income, northern and remote communities.

## 5. Prevention: Exposure, Sensitization and Provocation

MCS requires careful distinction between the exposures associated with onset or sensitization and the subsequent provocation of symptoms by later exposures. This is also distinct from the regulatory concept of skin sensitization. Research relevant to MCS has examined sensory and chemosensory pathways, including transient receptor potential (TRP) ion channels such as TRPA1 and TRPV1, and human experimental studies exist for activation and sensitization-related responses to some chemical stimuli.

Recent peer-reviewed Canadian research provides further evidence relevant to this distinction. Diallo et al. (2026a) documented self-reported chemical exposures associated with both the onset of MCS and subsequent symptom provocation among adults with diagnosed MCS. The findings reinforce the importance of examining exposures associated with the initial development of MCS separately from the exposures that provoke symptoms once the condition is established.

**Importantly, this area is already being considered within the evolution of Canadian chemical risk assessment.** In a 2026 presentation on chemical risk assessment under CEPA and the Chemicals Management Plan, a scientific evaluator with Health Canada's Existing Substances Risk Assessment Bureau identified gaps in the current risk-assessment framework for conditions including MCS, noting limitations of traditional animal testing for assessing symptoms such as headache, dizziness and fatigue. He described the development of **New Approach Methodologies (NAMs)** designed to identify chemical modes of action that may relate to MCS triggers, including assays examining whether chemicals activate **transient receptor potential (TRP) channels**, which have been hypothesized to be involved in triggering MCS symptoms. He further explained that identifying chemicals that activate these pathways could help improve chemical risk assessment and determine whether such chemicals may pose risks to human health. This emerging work provides a concrete pathway for Canada to investigate mechanisms relevant to MCS rather than allowing existing methodological limitations to perpetuate the evidence gap.



The same presentation identified cumulative exposure assessment as an evolving direction under CEPA for addressing real-world exposure scenarios and improving consideration of different subpopulations. This is particularly relevant to MCS, where exposures occur in complex mixtures and susceptibility and response may differ across the population.

Detection of a VOC does not, by itself, establish that the substance causes MCS or sensitization. At the same time, limited evidence of harm must not be interpreted as evidence of safety. This is particularly important because people are exposed to complex and changing mixtures of chemicals in real-world indoor environments, while the health effects of many mixtures, repeated low-level exposures and interactions among substances remain inadequately understood. This uncertainty strengthens, rather than weakens, the case for prevention. Source control should be the first line of protection, supported by meaningful ingredient and emissions transparency so that problematic sources can be identified and avoided. Avoidable hazardous and accessibility-limiting exposures should be eliminated wherever feasible; where elimination is not presently possible, exposures should be minimized while the necessary research is undertaken.

For people already sensitized, low concentrations that are below occupational or general-population guidance values may still be reported as symptom-provoking and functionally disabling. This illustrates a crucial distinction: an environment may comply with toxicological or occupational exposure guidelines and still present an accessibility barrier for a person with MCS. Regulatory compliance therefore does not, by itself, establish disability accessibility. For this reason, reducing avoidable exposures through effective source control is essential to creating and maintaining accessible environments for people with MCS.

## 6. Canadian Indoor Air Research Shows That Source Control Matters

ASEQ-EHAQ's Accessible Indoor Air in the Built Environment research, funded in part by Accessibility Standards Canada, compared office environments with scent-free policies to offices without such policies and measured total volatile organic compounds (TVOCs), the top 35 VOCs, formaldehyde, particulate matter, carbon dioxide and other indoor-air parameters. The research found approximately 70% lower TVOC concentrations in scent-free offices, along with lower concentrations or an absence of VOCs of concern. The project also estimated that achieving a comparable reduction through ventilation alone would require roughly three times the ventilation rate, underscoring the importance of source control.

The project's VOC and product profiling further demonstrates why environmental justice cannot rely solely on whether a product is marketed as "green," "eco-friendly," "scent-free" or similar. Products actually in use in the sampled office buildings were selected for laboratory emissions testing using a defined scientific methodology, including products from both scent-free-policy and no-policy spaces. Across the 15 products tested — 11 conventional and four fragrance-free/"green" — 280 VOCs were detected. Compounds of health relevance were identified in both product categories. Notably, the



fragrance-free/“green” products also emitted chemicals of concern, including benzene, chloroform and acetaldehyde.

The gap between measured emissions and the information available to purchasers was substantial. Among 190 VOCs identified across the conventional products, only 10 appeared on any product label. Among 90 VOCs identified across the fragrance-free/“green” products, none appeared on the product labels. Some products disclosed only one ingredient while describing virtually all remaining contents as “other ingredients.” These findings demonstrate a substantial gap between measured product emissions and the chemical information available to purchasers through product labels and environmental marketing claims.

The technical VOC profiles also show unevenness in the health evidence base. Some detected compounds have substantial toxicological information and established indoor-air reference values; for others, compound-specific human, chronic, inhalation or indoor-air guidance is limited or absent. Many limited-data profiles state that no studies were located or that long-term studies were not located. Limited or absent evidence of harm should not be interpreted as evidence of safety.

Real-world indoor exposure occurs as complex and changing mixtures, not one compound at a time, and some VOCs can participate in indoor chemistry that produces secondary pollutants. The health effects of many mixtures, repeated low-level exposures and interactions among substances remain inadequately understood. Research and regulation should therefore move beyond single-chemical, single-threshold approaches where the evidence supports doing so. These uncertainties strengthen the case for precaution, source control and meaningful chemical and emissions transparency; they should not become a rationale for inaction.

Recent peer-reviewed research further supports the importance of well-designed and effectively implemented fragrance-free policies as a source-control and accessibility measure. A 2026 scoping review identified important variation and gaps in policy definitions, scope, implementation and evaluation, while a complementary qualitative-dominant mixed-methods study documented perceived implementation gaps through the lived experience of people with MCS. Together, these findings reinforce that adopting a fragrance-free policy is not sufficient on its own: policies require clear definitions, comprehensive source-control measures, effective communication, consistent implementation and attention to the accessibility needs of people affected by chemical and fragranced exposures (Roy, Diallo, et al., 2026; Roy, Molot, et al., 2026).

## 7. Chemical Transparency Is an Environmental Justice Measure

People cannot meaningfully prevent exposure when they do not know what products contain or emit. Chemical transparency is therefore not only a consumer-information issue; for people with MCS and other susceptible populations it can be an accessibility and prevention measure.

For people with MCS, this information can be essential to accessibility. People with MCS, their families, employers, healthcare facilities and other institutions may deliberately select products marketed as “green,” “eco-friendly,” “low-VOC,” “unscented” or “fragrance-free” in an effort to reduce



exposures and create accessible environments. Yet the product-testing findings described above demonstrate that these claims do not necessarily provide sufficient information about what a product contains or emits. When undisclosed chemicals are present or emitted, people may experience exposures despite having taken reasonable precautions, while employers and institutions may incorrectly believe that an accessibility barrier has already been addressed.

**There is also an important equity consequence when these efforts fail.** If a person with MCS develops symptoms following exposure to a product believed to be “green,” fragrance-free or otherwise environmentally preferable, but neither the individual nor the institution has adequate information about its chemical composition or emissions, the reaction may be attributed to the individual rather than prompting investigation of the product or exposure. For a disability that is already poorly understood, and frequently stigmatized, inadequate chemical transparency can therefore contribute not only to exposure, but also to disbelief, failed accommodation and exclusion. **Chemical transparency is part of the infrastructure of accessibility.**

Canada should strengthen disclosure and hazard communication for consumer and institutional products, including clearer information about ingredients, emissions where relevant, and known hazards such as carcinogenicity, mutagenicity, reproductive toxicity, respiratory sensitization and skin sensitization. Canada should build on existing scientific evidence concerning chemicals and mechanisms associated with sensitization and symptom provocation in MCS, while supporting research to address remaining knowledge gaps and developing appropriate methods for their evaluation within chemical risk assessment. Where MCS-relevant chemical hazards are sufficiently established, they should be communicated through product disclosure and labelling requirements alongside other recognized health hazards. Environmental marketing claims such as “green,” “eco,” “natural,” “non-toxic,” “low-VOC,” “unscented” and “fragrance-free” should be subject to rigorous, transparent and enforceable standards so that consumers, workers and institutions can make informed choices. Where products are selected to meet disability-related accessibility needs, reliable information is especially important.

Scientific and regulatory terminology must remain precise while this work advances. Evidence concerning TRP activation, sensitization and altered responses relevant to MCS should not be conflated with established regulatory classifications for skin or respiratory sensitizers. However, the absence of an established regulatory hazard classification specific to MCS should not become a reason for permanent regulatory silence. Health Canada has itself identified gaps in conventional risk assessment for MCS and described emerging New Approach Methodologies (NAMs), including assays examining chemical activation of TRP channels, as a potential means of improving assessment of chemicals relevant to MCS. Canada should build on the existing human and mechanistic evidence, together with emerging NAM approaches and further research where needed, to validate and operationalize methods for assessing MCS-relevant chemical hazards within chemical risk assessment and, where supported by the evidence, communicating those hazards through product information and labelling. In the interim, better emissions data, chemical transparency and precautionary source control are warranted.



## **8. Data Justice: People Missing From the Data Risk Being Missing From Policy**

The draft Strategy appropriately identifies data gaps and, in the Indigenous context, the importance of data sovereignty. MCS surveillance illustrates why this matters.

The preliminary 2025 MCS supplement covers adults aged 18 and older and excludes the territories. Earlier CCHS cycles included people aged 12 and older, while some historical CCHS target populations also excluded First Nations people living on reserve and people in certain remote regions. Territorial MCS prevalence figures used in existing ASEQ-EHAQ mapping are therefore drawn from 2015–2016 data because of collection constraints, rather than from the 2020 provincial cycle.

These limitations must be made visible. Future national MCS surveillance should include children and youth, the territories and adequate northern and remote coverage. Indigenous-specific data collection and interpretation must be distinctions-based, community-engaged and consistent with Indigenous data governance and sovereignty. Territorial data must never be treated as a proxy for Indigenous data.

**People who are invisible in the data risk becoming invisible in policy.**

## **9. Indigenous and Northern Environmental Justice**

Environmental justice for Indigenous Peoples must be grounded in Indigenous rights, distinctions-based engagement, Indigenous knowledge systems and data sovereignty, as the draft Strategy recognizes. Within that broader work, the experiences of Indigenous people living with MCS and people in northern and remote communities warrant specific attention.

At an ASEQ-EHAQ conference, Ian Kuster, an Indigenous citizen living in Yukon, described the onset of health problems after moving into low-cost housing as a young adult, years of chemical exposures in Yukon homes, progressive loss of health and work capacity, and difficulty obtaining appropriate medical understanding. As his health deteriorated, he began investigating indoor air quality, chemical exposures and their relationship to his symptoms himself, illustrating the burden placed on individuals when appropriate environmental-health knowledge and services are unavailable. His testimony demonstrates why recommendations to “avoid exposure” can be unrealistic where alternative housing, specialized healthcare and other supports are scarce.

The final Strategy should support direct engagement with First Nations, Inuit and Métis people living with MCS and other exposure-related disabilities, including northern and remote communities, to identify locally appropriate priorities in housing, healthcare, environmental monitoring, product use, emergency response and accessibility.



## 10. Disability Rights and Environmental Justice Belong Together

Environmental justice and disability rights converge when environmental conditions determine whether a person can enter a building, obtain healthcare, work, study, secure housing or participate in public decision-making. In 2025, the United Nations Committee on the Rights of Persons with Disabilities specifically referenced Multiple Chemical Sensitivity in its Concluding Observations on Canada. **Under Article 5 — Equality and non-discrimination, the Committee specifically identified discrimination and stigmatization of people with multiple chemical sensitivity.**

Medical and professional recognition is also evolving. In 2025, the American Medical Association (AMA) adopted fragrance-related policy supporting fragrance-free environments, research and accommodation. In Canada, in 2026, the Canadian Medical Association has also endorsed the AMA policy relevant to fragrance sensitivity. These developments reinforce the need for governments to treat environmental accessibility as a legitimate disability and public-policy issue rather than waiting for perfect scientific certainty before removing preventable barriers.

## 11. How MCS Fits the Strategy's Four Priority Areas

| Draft Strategy priority                                                     | MCS / environmental accessibility gap                                                                                                                        | Recommended federal response                                                                                                                                                                                |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Embed environmental justice across federal institutions                  | Environmental exposure and disability accessibility are not consistently integrated into environmental, procurement, building, health and program decisions. | Apply an environmental-accessibility lens across federal policies, facilities, procurement, chemical management, program design and GBA Plus; explicitly include MCS among vulnerable/affected populations. |
| 2. Strengthen collaboration across governments and organizations            | Responsibility is fragmented across environment, health, disability, housing, employment and workplace policy, consumer products and human rights.           | Create a coordinated federal workstream involving ECCC, Health Canada, ESDC, Statistics Canada, housing and accessibility bodies, with provincial/territorial, Indigenous, research and community partners. |
| 3. Improve participation of communities most affected by environmental harm | People with MCS can be excluded from meetings and consultations by fragranced products, cleaning agents, indoor environmental conditions                     | Make federal engagement environmentally accessible: fragrance-free and source-control protocols; advance notice of activities that may                                                                      |



|                                                        |                                                                                                                                                |                                                                                                                                                                                                                                      |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        | at meeting locations and travel requirements.                                                                                                  | introduce chemical exposures, including through products marketed as “green” or “eco-friendly”; remote and written participation options; and protection from retaliation when requesting accommodation.                             |
| 4. Learn from experience and prevent future challenges | Canada lacks complete surveillance, clinical infrastructure, mixture/low-level exposure research and transparent product-emission information. | Fund research and surveillance; include children and territories; address Indigenous data gaps appropriately; strengthen chemical transparency; evaluate source-control interventions; and use lived experience to guide prevention. |

## 12. Recommended Actions for the Final Strategy

**Explicit recognition:** Name people living with Multiple Chemical Sensitivity among populations vulnerable to environmental harm and recognize environmental accessibility as an environmental justice issue.

**A two-obligation framework:** Operationalize environmental justice as both addressing the needs of people already harmed, and preventing future harm.

**National Centre of Excellence on MCS and publicly funded clinical capacity:** Establish and sustainably fund a National Centre of Excellence on Multiple Chemical Sensitivity to provide coordinated Canadian leadership on healthcare, research, prevention, environmental accessibility and accommodation, supported by expanded publicly funded clinical capacity across provinces and territories. The Centre should identify research priorities and knowledge gaps; support the development and evaluation of diagnostic and treatment approaches; develop evidence-informed clinical, environmental and accommodation protocols; advance prevention and accessible indoor environments; and translate emerging evidence into practical guidance for federal, provincial and territorial governments, healthcare systems, workplaces, housing providers and other institutions. Regional centres or other appropriate publicly funded models of specialized and multidisciplinary care should allow Canadians to access knowledgeable MCS healthcare without geography determining whether care is available.

**Clinical capacity should be built through direct knowledge transfer from physicians and other healthcare professionals with substantial experience caring for people with MCS, drawing on expertise from Canada and internationally.** This expertise should inform the training of a new



generation of Canadian clinicians while being subjected to rigorous research and evaluation. The Centre should investigate the full range of approaches currently used in MCS care — including exposure prevention and management, environmental interventions, rehabilitation and symptom management, as well as pharmacological and non-pharmacological approaches — examining effectiveness, safety, patient-reported outcomes and quality of life. Promising approaches should be studied rather than dismissed because they fall outside conventional models of care.

**People with lived experience of MCS must have a strong and meaningful role in the Centre's governance, priority-setting, research and development of clinical and accommodation guidance.** Their role should extend beyond consultation after decisions have been made. People living with MCS bring essential knowledge about exposures, functional limitations, barriers to care, accommodations and interventions that have or have not helped them. That knowledge should help determine what questions are studied and which outcomes matter.

The Centre could provide a national coordinating function while respecting provincial and territorial jurisdiction, enabling evidence, protocols and effective practices to be developed centrally and adapted across Canada rather than requiring every jurisdiction to independently recreate expertise that is presently scarce.

**Accessible federal environments:** Adopt effective fragrance-free/source-control approaches and healthy, lowest-VOC, least-toxic procurement and maintenance practices in federal workplaces, services and public-facing facilities.

**Healthcare:** Work with health-system partners to develop physician and healthcare-professional education, clinical guidance, accessible care pathways and environmentally accessible healthcare settings.

**Housing — an immediate and urgent need:** Treat access to appropriate housing for people with MCS as an immediate environmental-justice and disability-accessibility priority. People already sensitized cannot meaningfully “avoid exposure” when they cannot find or afford housing with appropriate indoor-air conditions, low-emission materials and effective source control. Canada should support the development and expansion of affordable, accessible housing designed to meet these needs, including innovative models informed by lived experience. **ASEQ-EHAQ's ECOASIS initiative provides a Canadian model of work toward housing specifically designed around the environmental and accessibility requirements of people with MCS.** Federal housing, accessibility and environmental-health programs should support the development, evaluation and scaling of such models, including demonstration projects and research to establish evidence-informed design, construction, renovation and operational standards.

**Chemical and product transparency:** Strengthen ingredient and emissions disclosure, hazard communication and enforceable standards for environmental and health-related product claims. Establish a regulatory pathway for identifying and, where scientifically established, communicating MCS-relevant chemical hazards alongside other recognized health hazards. Claims such as “green,”



“eco,” “natural,” “non-toxic,” “low-VOC,” “unscented” and “fragrance-free” should be evidence-based, clearly defined and independently verifiable.

**Particular scrutiny should apply to advertising that explicitly or implicitly claims that a consumer product can alter health, mood, behaviour, alertness, relaxation or sleep — including marketing suggesting that a product can calm, quiet, relax or help children or adults sleep.** Where manufacturers make claims implying physiological, neurological, behavioural or therapeutic effects, Canada should require an evidentiary and regulatory standard commensurate with the nature of the claim, rather than permitting such claims to function as ordinary lifestyle advertising. Claims directed at or concerning children warrant particular protection. **A product should not be able to imply a drug-like effect in its advertising without being required to substantiate that effect and address the corresponding safety implications.**

**Persistent and intentionally long-lasting emissions require particular attention.** Some consumer products, including laundry scent boosters and other fragranced laundry products, are marketed specifically on the basis that fragrance will remain on fabrics for extended periods after washing. Such persistence can result in secondary exposures when treated clothing and textiles are brought into workplaces, healthcare facilities, housing and other shared environments. For people with MCS, persistent fragrance residues can create significant accessibility barriers and may be difficult to remove from contaminated fabrics and other materials. Canada should investigate the chemicals and technologies used to create persistent fragrance effects, their emissions and transfer to other materials, the effectiveness of removal through ordinary laundering, and the implications for susceptible populations and disability accessibility.

Where persistence is an intended product characteristic, consumers should be clearly informed of that characteristic and of relevant ingredients and emissions. Claims promoting extended fragrance duration should also be considered in assessing exposure, accessibility and product safety. **This is not solely a matter of individual consumer choice: persistent residues and emissions can result in involuntary third-hand exposures for people who did not purchase or use the product and who may be unable to avoid the resulting exposure in essential shared environments.**

**Prevention and source control:** Prioritize elimination of avoidable hazardous and accessibility-limiting sources, and safer substitution and source control before relying on ventilation alone.

**Research:** Fund a coordinated MCS research agenda including mechanisms, TRP pathways, diagnosis, treatment, exposure-response, age of onset and life-course impacts, mixtures, chronic low-level exposure, indoor chemistry, product emissions, biomarkers and accessible intervention research. Undertake an updated national economic-burden analysis using contemporary Statistics Canada data, including employment, income, absenteeism, productivity, healthcare utilization, disability supports, housing and the costs and benefits of prevention and accommodation.

**Data justice:** Maintain regular national MCS surveillance with consistent measures; include children/youth and territories; improve northern/remote coverage; and pursue Indigenous-specific data only through appropriate distinctions-based governance and partnerships.



**Participation and protection:** Ensure people with MCS can participate in environmental decision-making through accessible engagement options and strengthen awareness of accommodation and anti-retaliation obligations.

**Accountability:** Assign federal leads, timelines and measurable indicators for environmental accessibility, surveillance, healthcare, housing, product transparency and participation, with public progress reporting through 2031.

### 13. Conclusion: An Opportunity to Change the Trajectory

Canada's first National Strategy on Environmental Racism and Environmental Justice is an opportunity to broaden the country's understanding of environmental harm before existing gaps become embedded for another generation. MCS demonstrates why environmental justice must consider not only where hazards are located, but also how routine and cumulative exposures interact with disability, income, sex/gender, housing, healthcare access, geography and the ability to participate fully in society.

Approximately **one in ten Canadian adults now reports MCS** in preliminary 2025 data, including approximately **one in eight adult women**. Canada also has more than two decades of population evidence documenting a substantial diagnosed population, alongside Canadian evidence of socioeconomic exclusion, inadequate access to knowledgeable healthcare, accommodation barriers, and preventable exposures in indoor environments. The potential economic consequences are also substantial: an earlier Canadian analysis estimated **more than \$25 billion annually in potential lost earned income alone**, and the full economic burden associated with the much larger population now reporting MCS has not yet been calculated.

Canada does not need to wait for every scientific question to be resolved before acting on what is already known. **People already harmed need recognition, knowledgeable healthcare, accessible housing, workplaces and public environments, and effective accommodation now.** At the same time, Canada must prevent future harm through source control, chemical and product transparency, healthier indoor environments, better surveillance, research, and the elimination of avoidable hazardous and accessibility-limiting exposures wherever feasible.

The final Strategy should explicitly recognize **people with MCS among populations vulnerable to environmental harm** and establish the infrastructure needed to turn recognition into action. A **National Centre of Excellence on MCS**, supported by publicly funded clinical capacity across Canada and informed by experienced clinicians, researchers and people with lived experience, could provide the national leadership needed to advance healthcare, research, prevention, environmental accessibility and accommodation.



**The scale of MCS, the human consequences of exclusion, and the economic costs of inaction make continued invisibility increasingly difficult to justify. This is an opportunity for Canada to change the trajectory.**

**Do not create preventable disability — and do not abandon people once disability has occurred.**

**Prevention without addressing existing harm leaves those already harmed behind.  
Addressing existing harm without prevention allows avoidable harm to continue.**

**Environmental justice requires both.**



## Selected Evidence and Resources

Environment and Climate Change Canada. Draft National Strategy Respecting Environmental Racism and Environmental Justice 2026–2031. <https://www.canada.ca/en/environment-climate-change/services/strategic-policy-branch/environmental-justice/draft-national-strategy.html>

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**Molot, J. (2026).** *The Mechanisms of Multiple Chemical Sensitivity (MCS) and the Bradford Hill Criteria for Causation*. Resilience: MCS Conference 2026, Environmental Health Association of Québec and Environmental Health Association of Canada. **Video forthcoming online September 14, 2026.** Conference information: <https://aseq-ehaq.ca/en/resiliencemcsconference-2026/>

**Tambasco, D. (2026).** *Clinical Reality, Systemic Barriers, and Pathways Forward in Multiple Chemical Sensitivity (MCS)*. Environmental Health Clinic, Women's College Hospital; University of Toronto. Resilience MCS Conference 2026, ASEQ-EHAQ. **Video forthcoming online September 14, 2026.** Conference information: <https://aseq-ehaq.ca/en/resiliencemcsconference-2026/>

**Psaradellis, E. (2025).** Redefining Clinical Perspectives on MCS: Toward an Evidence-Based, Multisystem Model. Comment on Jacques, L. *Multiple Chemical Sensitivity: A Clinical Perspective*. *Brain Sci.* 2024, 14, 1261. *Brain Sciences*, 15(7), 747. <https://doi.org/10.3390/brainsci15070747>

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UN Committee on the Rights of Persons with Disabilities. Concluding Observations on Canada.

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## Recent Peer-Reviewed Research

Diallo, N. A., Molot, J., Bray, R., Trifunovski, A., & Peris, R. (2026). *Self-Reported Chemical Exposures at Onset and Symptom Provocation in Adults with Multiple Chemical Sensitivity: A Descriptive Cross-Sectional Survey*. *International Journal of Environmental Research and Public Health*, 23(9), 1092. <https://doi.org/10.3390/ijerph23091092>

Diallo, N. A., Molot, J., Bray, R., Trifunovski, A., & Peris, R. (2026). *When Disability Recognition Fails: Accommodation Refusals and Socioeconomic Challenges Among Canadians with Multiple Chemical Sensitivity*. *International Journal of Environmental Research and Public Health*, 23(8), 1076. <https://doi.org/10.3390/ijerph23081076>

Roy, S., Diallo, N. A., Molot, J., Lattanzio, R., Bray, R., Armstrong, J., & Peris, R. (2026). *Fragrance-Free Policies in Practice: Identifying Perceived Implementation Gaps Through Lived Experience in a Qualitative-Dominant Mixed-Methods Study*. *International Journal of Environmental Research and Public Health*, 23(8), 1077. <https://doi.org/10.3390/ijerph23081077>

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## Related 2026 Preprints

<https://doi.org/10.20944/preprints202607.0676.v1>

<https://doi.org/10.20944/preprints202607.1732.v1>

<https://doi.org/10.20944/preprints202607.0685.v1>

<https://doi.org/10.20944/preprints202607.0743.v1>

## Lived Experience and Public Education

The Air We Share — Why Indoor Air Quality and Scents Matter for Accessibility: [presentation](#)