Sheffield Hallam University

HIV/AIDS, obesity and stigma: A new era for non-discrimination law?

MCTIGUE, Peter, FLINT, Stuart W. and SNOOK, Jereme <http://orcid.org/0000-0003-3248-7143>

Available from Sheffield Hallam University Research Archive (SHURA) at:

http://shura.shu.ac.uk/14887/

This document is the author deposited version. You are advised to consult the publisher's version if you wish to cite from it.

Published version

MCTIGUE, Peter, FLINT, Stuart W. and SNOOK, Jereme (2018). HIV/AIDS, obesity and stigma: A new era for non-discrimination law? In: SARAT, Austin, (ed.) Studies in Law, Politics, and Society. Studies in Law, Politics, and Society, 76 (76). Emerald Group Publishing Limited, 51-74.

Copyright and re-use policy

See http://shura.shu.ac.uk/information.html

Sheffield Hallam University Research Archive
http://shura.shu.ac.uk

HIV/AIDS, Obesity and stigma: a new era for non-discrimination law?

Peter McTigue,

Nottingham Law School, Nottingham Trent University, Nottingham, UK

Stuart W. Flint

Carnegie School of Sport, Leeds Beckett University, Fairfax Hall, Headingley Campus, Leeds, UK

Jeremé Snook

The Department of Law, Sheffield Hallam University, Sheffield, UK

Corresponding author

Peter McTigue, Nottingham Trent University, Burton Street, Nottingham, NG1 4BU

Email: peter.mctigue@ntu.ac.uk

Abstract

This aim of this paper was to explore commonalities between HIV/AIDS related conditions, obesity and other disabling impairments as health-related barriers that limit opportunity and advancement in society and the workplace. Taking a number of examples from original fieldwork and European Union and United Kingdom law, we posit that 'disability discrimination' under European Union law remains an indefinite, imprecise and incomplete area that requires greater alignment with the social model of disability. The principle attributes of societal discrimination towards people living with HIV and obese people are that these conditions are perceived to be primarily or in some instances, solely caused by controllable factors related often to behaviours and lifestyle choices. Strong beliefs that these conditions are controllable, is perceived as a justification and in some instances encouragement for the creation of stigma and discriminative behaviours that are unjust and uninformed. The structure of the paper is as follows. First, this paper postulates how and why stigma exists towards both individuals with disabilities and also obese individuals and people living with HIV; second, reviews the legal framework on disability discrimination in both United Kingdom and European Union courts that are directly relevant to the concepts of obesity and HIV-AIDS; third, presents critical thoughts as to the extent to which emerging decisions of the Court of Justice of the European Union concerning obesity and HIV-AIDS accord with the social model of disability; and fourth, offers an analysis of the implications of the United Kingdom and European framework and suggests possible interventions in this area. .

Keywords: *HIV, AIDS, obesity, discrimination, law*

Introduction

Over time the prevalence of HIV/AIDS and obesity has increased worldwide. It is estimated that 35 million people worldwide have HIV/AIDS and 600 million people are obese (World Health Organisation, 2014, 2015). Thus, HIV/AIDS and obesity are conditions of current concern with increasing prevalence and concomitant rise in stigma towards members both groups. The focus on HIV/AIDS and obesity reflects current academic and policy debates that highlight the potential of stigma to dilute the effectiveness of interventions in these areas. Both conditions have received the attention of the Court of Justice of the European Union (CJEU) in relation to cases concerning disability.

This aim of this paper was to explore commonalities between HIV/AIDS related conditions, obesity and other disabling impairments as health-related barriers that limit opportunity and advancement in society and the workplace. Taking a number of examples from original fieldwork and European Union (EU) and United Kingdom (UK) case law, we posit that 'disability discrimination' under EU law remains an indefinite, imprecise and incomplete area that requires greater alignment with the social model of disability. In order to address this assertion, the paper is divided into four sections. First, this paper postulates how and why stigma exists towards both people with disabilities and also obese individuals and people living with HIV/AIDS (PLHA); second, the paper reviews the legal framework in relation to disability discrimination in primarily UK and EU courts of direct relevance to obesity and HIV/AIDS; third, presents critical thoughts as to the extent to which emerging decisions of the Court of Justice of the European Union concerning obesity and HIV/AIDS accord with the social model of disability; and fourth, offers an analysis of the implications of the UK and EU legal framework and suggests possible interventions in this area.

Formation of stigma

In western societies the formation of negative attitudes and stigmatisation of obesity and HIV/AIDS appear to be dissimilar. One of the main sources that contributes to obesity stigma is the media exemplified by the commonality of fat jokes and derogatory portrayal of obese people (e.g., Flint, Hudson & Lavallee, 2016; Puhl & Brownell, 2001). In contrast, HIV/AIDS is considered a taboo topic that receives little media coverage and the stigmatisation and stereotyping of PLHA is typically considered an unacceptable topic for comedic response. Obesity stigma is a topic that is often reinforced and in many instances appears to be endorsed. For example, Flint et al. (2016) reported that UK national newspapers contained derogatory portrayals of obesity, including the stereotyping of obese people as slothful and gluttonous and there was no evidence to suggest that stigmatising and discriminatory behaviour is frowned upon. HIV/AIDS does not receive the same media coverage and whilst obesity stigma is reinforced to the recipient, there is a dearth of academic evidence for the stigmatisation of HIV/AIDS in the media. Mass media campaigns relating to HIV/AIDS are typically directed towards awareness-raising and there have been calls for campaigns to address stigmatising attitudes and stereotypes in the general population (Maharjan et al., 2008).

Previous research (e.g., Flint, Hudson & Lavallee, 2015) has demonstrated that obesity stigma is evident in diverse population groups measured on both a conscious and unconscious level. As such, obesity stigma has been reported in various settings such as schools, healthcare and workplaces (Flint, 2015; Flint & Snook, 2014; Flint, Čadek, Codreanu, Ivić, Zomer, & Gomoiu, 2016). Obesity stigma research has demonstrated that there is an association between attitudes towards obese people and beliefs about the controllability of obesity. Thus, if an individual believes that obesity is controllable (i.e., caused by unhealthy consumption and inactivity) is it likely that they will form negative

attitudes towards obese people. This is the result of an ability to assign blame to obese people, whereas an individual who believes that obesity is uncontrollable (i.e., genetically influenced) is less likely to form negative attitudes towards obese people. Likewise, previous research (Seacat et al., 2007) has demonstrated that beliefs about the controllability of HIV/AIDS (e.g., contracted through unprotected sex) rather than uncontrollable causes (e.g., contracted at birth) are also likely to influence negative attitudes towards HIV-AIDS people. One explanation for HIV/AIDS and obesity stigmatisation is Attribution Theory (Weiner, 1995), which postulates that individuals' beliefs about controllability influence subsequent actions. Thus, when HIV/AIDS and obesity are believed to be controllable, it is likely that an individual will develop negative attitudes towards HIV/AIDS and obese people through an ability to assign blame. Alternatively, individuals who believe that there are uncontrollable causes of HIV-AIDS and obesity are less likely to develop negative attitudes towards PLHA and obese people. The attribution of HIV/AIDS and obesity to causes believed to be under a person's control has consistently been reported as a factor leading to stigmatisation. This has also been evidenced in research reporting on self-stigmatisation (e.g., Flint et al., 2015; Mak, Poon, Pun, Cheung, 2007).

We posit that the relationship between HIV/AIDS and obesity with disability discrimination are societal and workplace issues. Within society and the workplace, citizens are expected to respect the importance of preventing discrimination against others with a possible disabling characteristic (e.g., impairments to understanding, hearing, sight and mobility). Responsible societies and citizens prohibit and prevent discriminatory behaviours and practices especially against those with disabling characteristics, for example mental impairments to reasoning or physical impairments. However, in the case of HIV/AIDS and obesity, society and citizens may be unaware of stereotyping and stigmatisation of others that

emanates from our knowledge deficits about HIV/AIDS, and obesity as defined by Body Mass Index (BMI).

Legal regulation prohibits discriminatory activities and encourages responsible societies, citizens and its workplaces to promote the inclusion of others with disabling conditions by using non-discriminatory practices and language. However, where the law is inadequate and/or inflexible, PLHA or obese people have the potential to be subjected to stereotyping, stigmatization and discrimination with no concomitant legal remedy available. What are the implications for society, its citizens and workplaces if anti-discrimination laws cannot be employed to challenge discriminatory language, practices and stigmatising behaviours towards PLHA or obese people purely because they are not viewed as the potential subjects of discrimination or as disabled? Where can discriminatory behaviour be checked and reversed; how can law and society accommodate PLHA and those with obesity issues within the parameters of disability discrimination; how can stigmatizing practices in relation to HIV/AIDS and obesity be similarly challenged in order to maintain compatibility with other areas of anti-discrimination provisions in order to eradicate societal and workplace disability discrimination claims? These are key questions that face legislators, citizens and the courts.

The UK and EU legal Framework

Non-discrimination law is symmetrical meaning that it protects both the majority/advantaged group and the minority/disadvantaged group from discrimination (Waddington, 2015). For example, the consequence of this is that gender equality law protects both men and women within the workplace from discrimination reflected in EU and UK law (see Directive (EC) 2006/54 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast) and the

Equality Act 2010 respectively). However, disability non-discrimination law is generally asymmetrical in nature meaning that it only protects individuals with disabilities from discrimination. In addition, non-disabled people who receive adverse treatment in comparison with a person with a disability have no right, to claim that they have experienced discrimination on the grounds of disability.

The liberal conception of formal equality is one of consistency, thus likes must be treated alike (Barnard & Hepple, 2000). This reinforces the basic Aristotelian principle and forms the basis of our ideas about equality (Fredman, 2011). Yet this approach does not take into account the fact that there may be material differences between the two groups being compared so that without more substantive action, real equality is not achieved (Sargeant, 2008). To counter this, non-discrimination law in relation to individuals with disabilities employs the concept of reasonable accommodation at the EU level (Employment Equality Directive 2000/78/EC) and the duty to make reasonable adjustments at the UK level (s.20 Equality Act 2010). Only individuals who are defined as "disabled" for the purposes of the law are granted such rights and it is consequently crucial to examine the legal framework in order to ascertain how the concept of disability is defined.

The starting point in relation to a consideration of the legal framework prohibiting disability discrimination within the UK is the Equality Act 2010 (EA 2010). For the sake of clarity this article uses the term "UK" as the territorial scope of the EA is surprisingly complex and a full discussion is beyond the remit of this article. In terms of scope, the EA covers Great Britain (England, Wales and, with a few exceptions, Scotland) but apart from a few provisions not Northern Ireland which has transferred powers from Westminster on the areas of equal opportunities and discrimination. In Northern Ireland, the intention is to leave it to employment tribunals to determine whether the law applies 'depending for example on the connection between the employment relationship and Great Britain' (Explanatory Notes to

the Equality Act 2010, para. 15). The EA 2010 is the means by which the UK gives effect to its obligations under both EU and international law. The EA 2010 contains a number of protected characteristics at section 4 namely age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and finally sexual orientation. The definition of disability is provided at section 6 which states:

> "(1) A person (P) has a disability if—
>
> (a) P has a physical or mental impairment, and
>
> (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities."

This definition accords very much with the medical model of disability which locates disability within the individual. Thus, disability is a medical condition and consequently like all other conditions, can be treated by doctors to ensure that its symptoms are alleviated or eradicated (Oliver, 1996; Beaumont, 1996; Drimmer, 1992; Parsons, 1958). Yet, the EA 2010's adoption of a medical definition fails to appreciate the often-subtle interplay between society, discrimination and individuals with disabilities. This is best illustrated by the EA 2010's requirement that any impairment must affect the individual's ability to undertake normal day-to-day activities. Thus, Guidance issued by the Secretary of State under the EA 2010 clarifies that activities do not fall within the category of 'normal day-to-day' if they are normal only for a particular person or group. Indeed, *Goodwin v Patent Office* (1999) confirmed that:

> "What is a day-to-day activity is best left unspecified: easily recognised, but defined with difficulty. Thus, it is not directed to the person's own particular circumstances,

either at work or home. The fact that a person cannot demonstrate a particular skill, such as playing the piano, is not an issue before the tribunal, even if it is considering a claim by a musician." (p.309)

The EA 2010's focus on the concept of "normality" insidiously locates individuals with disabilities as socially inferior to non-disabled individuals. By its very language, the EA 2010 unwittingly discriminates against individuals with disabilities. The definition employed is couched in a comparative manner, which advances the concept of the able-bodied being as "normal". Disability is identified by reference to unfavourable deviance from the able bodied (Woodhams & Corby, 2003). Disabled individuals stray from this concept of normality – they are abnormal, unable to undertake "normal" day-to-day activities and are in need of help and support.

The adoption of the medical model as the primary definition of disability by the EA 2010 is thus controversial. Indeed, the medical model itself has been subject to substantial criticism by individuals with disabilities. Many individuals with disabilities contend that it is, in fact, society which disables physically impaired people as: "Disability is something imposed on top of our impairments by the way which we are unnecessarily isolated and excluded from full participation in society" (UPIAS, 1976, p 14).

To combat this, the use of a social model of disability has been advocated. According to the social model, disability is any societal factor imposing restrictions on disabled people. These can range from individual prejudice to institutional discrimination and from inaccessible public buildings to inaccessible transport systems (Oliver, 1996).

Curiously in certain limited circumstances the EA 2010 in common with the earlier Disability Discrimination Act 1995, favours the adoption of the social model of disability. Thus, where the impairment consists of a severe disfigurement, it is deemed to have a

substantial adverse effect on the person's ability to carry out normal day-to-day activities (Schedule 1, paragraph 3). Again with HIV, there appears to be use of the social model. Thus, paragraph 6 to Schedule 1 of the EA 2010:

> "(1) Cancer, HIV infection and multiple sclerosis are each a disability.
>
> (2) HIV infection is infection by a virus capable of causing the Acquired Immune Deficiency Syndrome."

Within Western societies HIV fits more comfortably within the social model (McTigue, 2015). Although HIV damages the immune system, leaving the infected person vulnerable to a variety of infections (called "opportunistic" infections to indicate that they arise in the setting of immune impairment). However, having HIV does not mean that an individual has AIDS and with early HIV diagnosis and access to effective treatment, most PLHA will never progress to a diagnosis of AIDS. Indeed, evidence now indicates that due to improved treatment options PLHA can be expected to live into their early seventies, a life expectancy approaching that of the general population (Samji et al., 2013; Sterne, 2005). Despite this high levels of stigma persist towards PLHA.

Conyers, Boomer and McMahon (2005) assert that two main theories assist us in explaining the unique level of discrimination and stigma directed at PLHA. The first centres on the characteristics of the virus itself, with significant focus placed upon the fact that it is currently a potentially fatal infectious disease with no cure. The second relates to the marginalized nature of the vast majority of PLHA (e.g., their status as intravenous drug users, men who have sex with men or members of ethnic minorities). Evidence reveals that discrimination against PLHA is often related to pre-existing stigma making PLHA particularly vulnerable to discrimination (Watt, 1996). The virus is thus socially disabling and

the fear of stigma often prevents PLHA from accessing full legal protection by, for example failing to disclose their condition to their employer.

In light of the above PLHA are deemed to be “disabled” for the purposes of the EA 2010 and obviated from the need to meet the definition of disability in section 6. Significantly, obesity is not specifically identified as a disabling condition within the EA 2010 and so a significant barrier to obese people wishing to pursue is the requirement to show that their condition constitutes a disability for the purposes of section 6. The definition provided at section 6 serves as a gatekeeper and only grants access to the full protection of disability discrimination law to those people it classifies as being or having been disabled (Lawson, 2011). Obese claimants thus must show an impairment that has 'a substantial and long-term adverse effect on their ability to undertake normal day-to-day activities’.

Recent UK rulings provide some insight to the changing approach to disability discrimination and obesity. For example, the UK legal ruling in *Walker v Sita Information Networking Computing Ltd* (2013) held that an obese employee suffering from a variety of physical and mental ailments was protected by the EA 2010 under UK laws. In *Walker* the claimant suffered conditions including dyslexia, diabetes, knee problems, high blood pressure, bowel and stomach complaints, anxiety and depression, coughs, and other more minor difficulties such as joint pains. In addition to health concerns associated with obesity, Walker was also diagnosed with ‘functional overlay’ recognised as a multiplicity of symptoms presenting in the patient. The original Employment Tribunal (ET) considered whether in total Mr. Walker's multiple conditions constituted ‘impairments’ for the purposes of the definition of disability under the EA 2010. These medical conditions affected Mr Walker’s normal activities, but significant issues arose with the definitions of ‘functional overlay’ within the current legal definition of discrimination found in the EA 2010.

At the first hearing (ET), it was decided that Mr. Walker was not disabled within the meaning of section 6 EA 2010 because there were no significant physical or organic cause for his symptoms. However, on appeal, the Employment Appeals Tribunal (EAT) ruled differently that medical definitions and labels cannot always be relied on to promote sustainable legal rulings. The EAT held that a claimant's disability could result from a physical impairment, a mental impairment or a combination of the two. Importantly, the EAT stressed that the obesity *on its own* does not render a claimant disabled, but significantly, it can increase the probability that the claimant is disabled for the purposes of disability discrimination laws. In the words of Langstaff J:

> "I do not accept that obesity renders a person disabled of itself, it may make it more likely that someone is disabled. Therefore on an evidential basis it may permit a Tribunal more readily to conclude that the individual before them does indeed suffer from an impairment or, for that matter, a condition such as diabetes, if that diabetes is such as to have a substantial effect upon normal day to day activities." (at paragraph 18).

Therefore, an obese person cannot be regarded as disabled simply because of obesity per se but the associated health problems of obesity increase the possibility that an obese individual may satisfy the definition of disability contained at section 6 of the EA 2010.

Langstaff J also emphasised that in determining whether an individual is disabled for the purposes of the EA 2010, the correct consideration is whether the individual has an impairment and not the cause of the impairment. This is aligned with the approach taken towards alcoholism. The EA 2010 (Disability) Regulations 2010 (S.I. 2010/2128) provide that an addiction or dependency to alcohol, nicotine or any other substance does not

constitute an impairment for the purposes of the EA 2010. However, this exclusion does not have the effect of preventing a complainant from relying on an impairment that was caused by an addiction. Therefore, cirrhosis of the liver could be considered an impairment even if it arose from alcoholism.

At EU level, protection from discrimination on the grounds of disability is more restricted in scope due to the fact that the relevant Directive, the Employment Equality Directive 2000/78/EC (2000) (the Framework Directive), only provides protection against discrimination in the fields of employment, occupation and vocational training. By way of contrast the EA 2010 provides protection in education, employment, premises, transport the provision services and public functions. The Framework Directive is expressly designed to "foster a labour market favourable to social integration" by "combatting discrimination against groups such as persons with disability," (at Recital 8) and Article 2(1) provides:

> "For the purposes of this Directive, the principle of equal treatment shall mean that there shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1."

The grounds referred to in Article 1 are religion or belief, disability, age and sexual orientation. The Framework Directive provides no definition of disability. This has the potential to permit multiple varying definitions of disability to be adopted across EU member states and for different domestic courts to adopt differing approaches as to whether a particular impairment constitutes a "disability". For example, PLHA are not automatically deemed to be disabled for the purposes of the Framework Directive and thus, in the absence of any relevant domestic legal protection, PLHA in member states other than the UK may fail to be regarded as disabled. Correspondingly, obesity discrimination, has not received

significant attention within the EU with obese people receiving limited legal protection to date (Damamme, 2015), although some member states do afford protection on the grounds of physical appearance.

Emerging decisions of the CJEU

In the seminal case of *Chacon Navas v Eurest Colectividades SA* (2006) the CJEU offered guidance on the issue of how to define "disability" for the purposes of the Framework Directive stating at paragraph 43 that:

> "[The Framework Directive] aims to combat certain types of discrimination as regards employment and occupation. In that context, the concept of 'disability' must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life."

In addition, the CJEU held that workers do not fall within the scope of the protection afforded by the Framework Directive as soon as they develop any type of sickness and so made an important distinction between sickness and disability. It was against this backdrop that the judgment in the case of *HK Danmark (Ring and Skouboe Werge*, 2013) was delivered by the CJEU. In *HK Danmark (Ring and Skouboe Werge*, 2013), Danish legislation permitted businesses to dismiss those who had been off ill for a certain number of days with only one month's notice; shorter than the notice normally required under Danish employment law. The case was brought by two applicants one of whom, Ms. Ring, had developed back pain. The second applicant, Ms. Werge, had whiplash following a road accident. Crucially, both applicants were still able to work but were unable to work on a fulltime basis. The applicants

argued that they had a disability, and that this reduced notice period was unlawful disability discrimination, in breach of the EU Framework Directive. A question of fundamental importance was whether or not they fell within the definition of disability as expounded by the *Chacon Navas* case. The employers disputed that the applicants' state of health was covered by the concept of "disability" within the meaning of the Framework Directive, since the only incapacity that affected them was that they were now not able to work full-time. As such it was argued by the employers that as they could work part-time they were not excluded completely from participating in professional life and so fell outside the *Chacon Navas* definition. The employer's central argument was that disability, as constructed by the decision in *Chacon Navas*, implies a complete exclusion from work or professional life as opposed to the partial exclusion here.

The CJEU disagreed and placed strong emphasis on the United Nations (UN) Convention on the Rights of Persons with Disabilities (the UN Convention) adopted by the UN General Assembly in December 2006, following prolonged lobbying by disability rights activists. It was ratified by the EU in 2010. The ratification of the UN Convention by the EU thus followed the *Chacon Navas* decision and accordingly it clearly follows from Article 216(2) TFEU that international agreements concluded by the EU are binding on the institutions of the EU and on its Member States. Thus, the concept of disability within the meaning of the Framework Directive should not fall short of the scope of the protection afforded by the UN Convention which itself does not include a definition of "disability" or "persons with disabilities". However, the Convention's preamble recognizes that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others". Article 1 of the UN Convention further states:

"Persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Yet the due to the progressive nature of the disease it is questionable whether PLHA will fulfil the CJEU's conceptual requirement of "disability" formulated in *HK Danmark (Ring and Skouboe Werge*, 2013). If a purely functional approach to the question of "participation in professional life" is taken, then the majority of PLHA face no functional or imitational barriers to participation in professional life. HIV damages the immune system, leaving an infected person vulnerable to a variety of infections yet having HIV does not mean that an individual has AIDS and importantly, with early HIV diagnosis and access to effective treatment most PLHA will never progress to a diagnosis of AIDS. Thus advances in medical treatment mean that HIV is now manageable as a chronic disease in patients who have access to medication and who manage to suppress their viral load (Pelella, Delany, Moorman, Loveless, Furhrer Satten et al., 1998). Yet whilst recent advances in treatment have prompted a biomedical normalisation of HIV as a manageable chronic condition, social normalisation of the virus has not progressed in tandem (Murphy et al., 2015). Thus, HIV is still associated with discrimination, isolation, and marginalisation (Rodkjaer, Sodemann, Ostergaard, & Lomborg, 2011; Smit et al., 2012), which inevitably leads to high levels of stigma being directed towards PLHA. This stigma impacts significantly on the lives of PLHA. It often results in discrimination, exclusion, and disempowerment (Gilmore & Somerville, 1994), leading people with HIV infection to self and societally imposed withdrawal and isolation (Barrett, 1995; Crandall & Coleman, 1992; Longo, Sprose, & Locke, 1990).

No cases are reported involving the issue of PLHA before the CJEU in order to definitely address this issue. By contrast the issue of whether obese individuals could fall within the scope of the protection afforded to individuals with disabilities by the Framework Directive was considered by the court in the case of *Kaltoft* (Fag og Arbejde, 2014). Mr Kaltoft had worked for fifteen years as a child-minder for the Danish municipality of Billund. He was responsible for taking care of people's children in their own homes. He was dismissed in November 2010 following an official dismissal hearing during which his obesity was mentioned. Before the national court, Mr Kaltoft asserted that he was discriminated on the grounds of his obesity. Against this background, the national court referred several questions for a preliminary ruling, asking notably whether obesity can fall within the definition of disability for the purposes of the Framework Directive. Advocate General Jääskinen appeared supportive of such an idea and expressly referred to the concept of body mass index (BMI). BMI is a formula that consists in dividing an individual's weight (in kilogrammes) by square of his/her height (in metres). The World Health Organisation (WHO, 2015) ranks obesity into three classes by reference to the BMI. Persons with a BMI of 30.00 to 34.99 are obese class I, persons with a BMI of 35.00 to 39.99 are obese class II, and persons with a BMI in excess of 40.00 are obese class III, which is sometimes referred to as severe, extreme or morbid obesity.

In Advocate General Jääskinen's opinion, obesity might amount to a disability when it reaches the point where it clearly hinders an individual's full participation in professional life on an equal footing with others. In his opinion, "most probably only WHO class III obesity, that is severe, extreme or morbid obesity, will create limitations, such as problems in mobility, endurance and mood, that amount to a 'disability' for the purposes of Directive 2000/78" (at paragraph 56). This appeared to suggest that obese people within class III would be regarded as disabled for the purposes of the Framework Directive. However, this argument

was rejected by the CJEU. In the Court's opinion obesity does not, in itself, constitute a 'disability' within the meaning of the Framework Directive (See Ferris & Marson, 2014 for detailed commentary on the Advocate General's opinion). This is not to say that obese individuals can never acquire protection as individuals with disabilities under the Framework Directive. Thus as acknowledged by the Court at paragraph 59:

> "[I]n the event that, under given circumstances, the obesity of the worker concerned entails a limitation which results in particular from physical, mental or psychological impairments that in interaction with various barriers may hinder the full and effective participation of that person in professional life on an equal basis with other workers, and the limitation is a long-term one, obesity can be covered by the concept of 'disability' within the meaning of Directive 2000/78 (see, to that effect, judgment in HK Danmark, EU:C:2013:222, paragraph 41)."

It is suggested that when obesity reaches the point where it manifests itself as a physical, mental or psychological impairment, then it may constitute a disability. Such impairment must, however, hinder the effective participation of an obese individual in professional life on a long-term basis. Finally, the origin of an individual's disability is irrelevant as is the fact that an individual may have contributed to the onset of their disability. Thus, as obesity substantially increases the risk of numerous impairments including for example hypertension (Stamler, Stamler, Riedlinger, Algera, & Roberts , 1978; Criqui, Mebane, Wallace, Heiss, & Holdbrook, 1982; Dyer & Elliott, 1989), type 2 diabetes (Westlund K, Nicolaysen, 1972; Lew E A, Garfinkel, 1979; Larsson B, Bjorntorp P, Tibblin 1981), strokes (Hubert, Feinleib, McNamara, Castelli, 1983; Walker, Rimm, Ascherio, Kawachi, Stampfer, & Willett , 1996), osteoarthritis (Cicuttini, Baker, & Spector, 1996;

Hochberg, Lethbridge-Cejku, Scott Jr, Reichle, Plato, & Tobin , 1995), sleep apnea and respiratory problems (Millman, Carlisle, McGarvey, Eveloff, & Levinson, 1995; Young, Palta, Dempsey, Skatrud, Weber, & Badr, 1993; Shephard, 1992), it is, we suggest, axiomatic that there is a greater probability that obese people will be disabled when compared to non-obese people.

The longer term implications of *Kaltoft* remain uncertain since it confirms that whilst obesity may be the underlying cause of disability, obesity per se is not a disability for the purposes of EU law. It is also unclear to what extent *Kaltoft* represents a possible modification of the social model for the purposes of EU law. When discussing whether obese individuals could theoretically satisfy the requirements of the Framework Directive the CJEU provided the following guidance at paragraph 60:

> "Such would be the case, in particular, if the obesity of the worker hindered his full and effective participation in professional life on an equal basis with other workers on account of reduced mobility or the onset, in that person, of medical conditions preventing him from carrying out his work or causing discomfort when carrying out his professional activity."

Whilst post the ratification of the UN Convention, the CJEU have referred to the social model of disability in subsequent cases concerning disability and the Framework Directive (for example see HK Danmark, 2013; Z. v A Government Department and The Board of Management of a Community School, 2013; Glatzel v Freistaat Bayern, 2014; Fag og Arbejde, 2014), these comments appear to place undue emphasis on the functional limitations that obese people might experience in their participation in professional life. Thus, the above quote solely refers to the fact that their participation might be hindered due to functional factors like "reduced mobility" or "medical conditions preventing him from carrying out his work or causing discomfort when carrying out professional activity." There

is no explicit reference to attitudinal or other societal factors that may prevent obese people from participating in professional life. This is quite possibly an oversight yet there remains the distinct possibility that the CJEU is at the early stages of developing the social model whilst attempting to retain components of the medical model (i.e., there must be at least some element of functional impairment). Indeed, such an approach was alluded to by the opinion of the Advocate General in the *HK Danmark (Ring and Skouboe Werge)* case. At paragraph 34 it was stated by the Advocate General that:

> "34. *The distinction between sickness and disability is therefore easier to draw in these cases than in the case on which the Supreme Court of the United States of America had to rule, where it held that even an asymptomatic HIV infection may constitute a disability within the meaning of the ADA 1990.*
>
> *35. There is nothing in the wording of Directive 2000/78 to indicate that its scope of application is limited to a certain degree of severity of disability. Since, however, this issue has been neither raised by the referring court nor discussed by the parties to the proceedings, it does not need to be definitively resolved here."*

With these facts in mind, it must be questioned whether PLHA or obese people will fall within the definition of "disability" advanced by the CJEU for the purposes of the Framework Directive in *HK Danmark (Ring and Skouboe Werge)*. It may be perceived as somewhat troubling as to why it was questioned whether a certain degree of severity of disability is required for the purposes of the Framework Directive. These comments could, especially when coupled with a reference to asymptomatic HIV, appear to place undue influence on the medical model of disability by possibly focusing on an individual's

functional limitations as opposed to the attitudinal barriers they might encounter which hinder them from full and effective participation in professional life. It is submitted that caution should be exercised in the interpretation of these passages and that, given the explicit references to the social model in its recent decisions, the direction of travel of the CJEU does still very much appear to favour the use of the social model of disability. Yet what lessons, if any, can be learnt from attitudinal theory that might assist in a more favourable implementation of the social model of disability in law. It is to this issue that this article will now turn.

Implications of the UK and EU Legal Framework and Potential Interventions

Studies have highlighted the increasing instances of obesity discrimination in various spheres of life such as in the workplace, at home, in education and in healthcare (e.g., Flint et al., 2016; Puhl & Brownell, 2001). Yet for the purposes of the law of the UK, there remains the distinct possibility that a PLHA and an obese person individual subjected to the same discriminatory act could experience a difference in the outcomes of their respective legal cases. This is due to the different protection afforded to PLHA and obese people. The automatic protection that PLHA receive under the disability provisions of the EA 2010 means that arguments as to the interpretation and application of the definition of disability have no impact on the admissibility of their case. They are automatically deemed to be disabled and thus entitled to advance a claim of disability discrimination. Conversely, if an obese person is to advance their claim of disability discrimination under the EA 2010 the first hurdle they must clear is satisfying the court or tribunal that they fall within the definition of disability in the EA 2010 and are consequently "disabled" for the purposes of the law. If they are unable to demonstrate that they fall within the parameters of this definition, their claim goes no further.

Some research has examined whether legal protection for obesity discrimination would be publically supported. For example, Puhl et al. (2015) examined possible public support for legislation to prohibit obesity discrimination in the US, Canada, Australia and Iceland, reporting that the public would endorse measures to prevent obesity discrimination in employment. They reported that approximately two thirds of participants were in favour of legislation that would prohibit employers from not hiring, paying lower wages, denying promotion, and ending employment based on the body weight. Previous research (e.g., Schulte et al. (2007) examining obesity discrimination in employment has demonstrated that obese employees receive lower starting salaries, are ranked as less qualified, and work longer hours than normal weight employees. Puhl et al. (2015) also reported that the public support for legislation prohibiting obesity discrimination was associated with controllability beliefs where more awareness of uncontrollable causes of obesity was associated with stronger support for laws. They also found that the greatest support for these laws was from women and people with higher body weight, which it might be argued is expected given that there are reports suggesting obesity discrimination is stronger for obese females than obese males (e.g., Flint et al., 2016).

At the EU level, the ratification of the UN Convention by the EU is to be warmly welcomed. Yet given the comments by the CJEU in recent decisions like *HK Danmark (Ring and Skouboe Werge)* and *Kaltoft* it appears that both PLHA and obese people who seek to rely on protection from discrimination using the terms of the Framework Directive may face an uphill battle in persuading the court that they are disabled for the purposes of the law. In *Kaltoft* the CJEU made no mention to the possible social and/or attitudinal barriers that might hinder the full and effective participation of obese people in professional life. Rather the Court emphasised the functional effects that obesity could have like reduced mobility or the onset of medical conditions that prevent work or cause discomfort. Nothing was said by the

CJEU about the possible stigma that obese people might face from their fellow workers and the extent to which this might hinder their full and effective participation in professional life. Similarly, in *HK Danmark (Ring and Skouboe Werge)*, the comments made by the Advocate General regarding PLHA appear to place undue influence on the medical model of disability by focusing on an individual's functional limitations as opposed to the stigma they might encounter in their professional life. In future decisions, the CJEU must recognize that the barriers which hinder the full and effective participation of disabled people in professional life go beyond just the environmental or physical but include attitudinal and psychological barriers. As such it must be hoped that a definition of disability which is firmly grounded in the social model and recognises the effects of stigma is developed in future CJEU decisions.

Academic and policy discussions of stigma often concentrate on Goffman's work (Goffman, 1963). Goffman's research draws upon the experience of people suffering from mental illness, possessing physical deformities, or practicing what were perceived to be socially deviant behaviours such as homosexuality or criminal behaviour and defines stigma as ''an attribute that is significantly discrediting'' (p.3) and which serves to reduce social standing of the person who possesses it. He identifies three bases of stigma. First, abominations of the body. Second, blemishes of individual character and third tribal stigma, due to an individual's membership of a despised group in society. Watt (1996) advances that stigmatization of individuals with HIV rests upon all three of Goffman's bases and consequently stigma is more pronounced. Whilst it is arguable that stigma amongst obese people is less pronounced than that against PLHA, it still has the potential to manifest itself in discrimination against obese individuals (Flint et al., 2016).

A concept, rooted in the social model, that might assist the protection of both PLHA and obese people at EU level would be for the CJEU to consider the development of protection for individuals based upon the fact that an individual's impairment hinders their

full and effective participation in professional life on an equal basis with other workers *as a result of other workers' attitudes towards their impairment* (See Damamme (2015) for a discussion regarding the position of U.S. law on this point). The obese person would still need to show that their obesity had manifested itself as an impairment. In addition, for both obese people and PLHA the limitation sustained must be long-term. This would further embed the social model of disability into EU law and was indeed the approach taken by the European Court of Human Rights in *I.B. v. Greece*, Application no. 552/10. Whilst the European Court of Human Rights is not a court of the EU, the CJEU cites and pays close attention to its decisions. There has also been a desire on the part of both Courts to avoid conflict and demonstrate a degree of deference towards each other on similar questions arising before them (Pâris-Bobozy, 2014, Craig and De Búrca, 2015).

In *I.B. v. Greece* applicant, I.B., was a Greek national who had been working since 2001 in a company which manufactured jewellery. In January 2005 he confided to three of his fellow employees that he was afraid he had contracted HIV. These three colleagues then wrote a letter to the director of the company stating that I.B. had AIDS and that the company ought to dismiss him. Following this information about I.B.'s health began to circulate around the company and I.B. stated that he was stigmatised by his fellow employees and treated like a pariah. On 10th February I.B. tested positive for HIV and the employer invited an occupational health doctor to come speak to the employees, to reassure them that there was no risk whatsoever to their own health. Despite this on 21st February, 33 of I.B.'s fellow employees sent a letter to the director of the company demanding his dismissal in order "to safeguard their health and their right to work" (para. 10). Two days later, I.B. was dismissed by the company.

The first national Court held that I.B.'s dismissal was illegal. The Court of Appeal also held that his dismissal was illegal. However, the Greek Court of Cassation quashed that

judgment deciding that his termination was justified in order to ensure the smooth functioning of the company and harmonious relations within it. Subsequently, I.B. complained to the European Court of Human Rights that his dismissal violated his right to a private life under Article 8 in conjunction with the prohibition of discrimination under Article 14 of the European Convention on Human Rights.

The European Court of Human Rights decided that Article 8 was engaged as I.B.'s dismissal and the stigma to which he had been subjected, was bound to have serious repercussions for his private life. The Court also stressed that when vulnerable groups like PLHA, were treated differently, States would only be afforded a very narrow margin of appreciation. Here, the treatment of I.B. fell outside that margin of appreciation and accordingly his human rights had been breached. Although no explicit reference was made to the UN Convention, the Court very much adopted the social model of disability approach. This can be seen from the wording used in paragraph 80:

> "People with HIV are forced to face multiple problems, not only medical but also professional, social, personal and psychological problems, and sometimes entrenched prejudices even amongst the well-educated." (translated from the French original).

Obese people also face entrenched prejudices. As previously mentioned, previous research (e.g. Flint, Hudson & Lavallee, 2015) has demonstrated that obesity stigma is evident in diverse population groups measured on both a conscious and unconscious level and obesity stigma has been reported in various settings such as schools, healthcare and workplaces (Flint, 2015; Flint & Snook, 2014; Flint et al., 2016).

Yet the law can only do so much to address stigma and discrimination. The potential for discrimination to occur and impact decisions, attitudes and behaviours calls for interventions at all levels. Interventions at Government, in the workplace and schools to prohibit HIV and obesity discrimination are warranted, as are interventions to modify stigmatising attitudes. Previous research (e.g., O'Brien et al., 2010) has demonstrated that educational intervention that aim to increase knowledge of uncontrollable causes, can reduce stigma towards population groups of that characteristic. This is in line with Attribution Theory (Weiner, 1995) which indicates that by increasing people's understanding of uncontrollable causes, a subsequent reduction in negative attitudes towards a stigmatised group can occur.

Given the influence of the media on attitude formation and subsequent behaviours, intervention is warranted to develop guidelines relating to non-stigmatising and discriminatory behaviours. The formation of attitudes and behaviours are linked to exposure to societal messages. The media are a pervasive and persuasive source that contributes to the formation of attitudes towards PLHA and obese people. Thus, it is imperative that the media adhere to non-stereotypical portrayal and by doing so, reduce the influence of the media in stigma development. Guidance for non-stereotypical portrayal has been observed in relation to UK national newspapers, where the Society for Professional Journalists (2010) stated that journalists should “avoid stereotyping by race, gender, age, religion, ethnicity, geography, sexual orientation, disability, physical appearance or social status” (p. 1). Despite this, Flint et al. (2016) reported that UK journalists do not adhere to this guidance and there appears to be little reprimand and therefore deterrent for non-adherence. Inaccurate and sensationalist reporting of matters relating to HIV and obesity contribute to stigma and discrimination and examples in relation to PLHA include headlining HIV as a cause for serious concern in stories where its relevance is at best tenuous (Wells, 2011) or in criminal cases of reckless

HIV transmission where the language used goes beyond criticism of the accused to imply an association of evil or criminality in all PLHA e.g. 'HIV monster (Taylor, 2011) and 'Evil HIV beast took my babies away from me (Cameron, 2010). Obese individuals are also subjected to media criticism with headlines resembling "'We're sick of fat people whingeing'(Kippist, 2013), "This Christmas give a fat person you know the greatest gift of all - some brutal honesty!" (Hopkins, 2015) or stories implying they are lazy and unwilling to work (Ware, 2016).

Conclusion

This article has highlighted the prevalence of stigma and discrimination towards PLHA and obese persons. When faced with such discrimination PLHA and obese persons often seek legal protection by utilising the protected characteristic of disability with varying degrees of success. By way of example, within the UK, PLHA face greater legal protection under the law due to their designation as "disabled" for the purposes of the EA 2010. Conversely, obese people are not automatically deemed disabled for the purposes of the law and must instead demonstrate that they fall within the EA 2010's definition of disability.

At the EU level, the CJEU signalled its willingness to adopt the social model of disability in the case of *HK Danmark (Ring and Skouboe Werge)*. Despite this, comments in relation to PLHA by the Advocate General in *HK Danmark* and the decision in relation to obese persons in *Kaltoft* appear to suggest that the Court is not yet willing to fully embrace the social model of disability. There is the possibility that the Court is placing undue influence on functional limitations when assessing whether individuals satisfy the definition of disability expounded by the Framework Directive. This approach potentially fails to acknowledge the societal stigma that PLHA and obese persons may encounter. To address this position and align the concept of disability at EU level more fully with the social model,

it is respectfully submitted that future decisions of the CJEU could develop protection for individuals based on the fact that their impairment hinders their full and effective participation in professional life on an equal basis with others as a result of other workers' attitudes towards their impairment. This would further embed the social model of disability into EU law and has the potential to afford greater protection for individuals who are often stigmatised by society.

References

Barnard, C. & Hepple, B. (2000). Substantive Equality. *The Cambridge Law Journal*, *59*, 562-585.

Barrett, R. K. (1995). Elephant people: The phenomena of social withdrawal and self-imposed isolation of people dying with AIDS. *AIDS Patient Care*, *9*, 240–244.

Beaumont, A. (1996). This Judicial Estoppel has got to stop: Judicial Estoppel and the Americans with Disabilities Act, 71 N.Y.U. L. Rev. 1529

Cameron, G. (2010). Evil HIV beast took my babies away from me. The Sun. http://www.thescottishsun.co.uk/scotsol/homepage/news/2817429/Evil-HIV-beast-Mark-Devereaux-took-my-babies-away-from-me.html [Accessed 24 May 2016].

Cicuttini, F. M., Baker, J. R., & Spector, T. D. (1996). The association of obesity with osteoarthritis of the hand and knee in women: a twin study. *Journal of Rheumatology*, *23*, 1221–1226.

Conyers, L., Boomer, K., & McMahon, B. (2005). Workplace discrimination and HIV/AIDS: The national EEOC ADA research project. *Work*, *25*(1), 37-48.

Crandall, C. S., & Coleman, R. (1992). AIDS-related stigmatization and the disruption of social relationships. *Journal of Social and Personal Relationships*, *9*, 163–177.

Craig, P., & De Búrca, G. (2015). *EU Law*. Oxford: OUP

Directive (EC) 2006/54 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast) [2006] OJ L204/23

Drimmer, J. (1992). Cripples, Overcomers and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities. *UCLA Law Review*, *40*, 1341-1410.

Criqui, M. H., Mebane, I., Wallace, R. B., Heiss, G., & Holdbrook, M. J. (1982). Multivariate correlates of adult blood pressures in nine North American populations: The Lipid Research Clinics Prevalence Study. *Preventative Medicine, 11,* 391–402.

Damamme, J. (2015). How can obesity fit within the legal concept of 'disability'? A comparative analysis of judicial interpretations under EU and US non-discrimination law after Kaltoff. *European Journal of Legal Studies, 8*, 148-179.

Dyer, A. R., & Elliott, P. (1989). The INTERSALT study: relations of body mass index to blood pressure. INTERSALT Co-operative Research Group. *Journal of Human Hypertension, 3,* 299–308.

Equality Act 2010.

Fag og Arbejde (FOA), acting on behalf of Karsten Kaltoft, v Kommunernes Landsforening (KL), acting on behalf of the Municipality of Billund. 2014. Case C-354/13.

Ferris, K. & Marson, J. (2014). 'Does Disability Begin at 40? Karsten Kaltoft v Kommunernes Landsforening (KL), acting on behalf of the Municipality of Billund (Advocate General's Opinion)'. *Web Journal of Current Legal Issues, 20,* http://webjcli.org/article/view/373/476 (accessed 22nd March 2016).

Flint, S. W. (2015). Obesity stigma: prevalence and impact in health settings. *British Journal of Obesity, 1*, 14-18.

Flint, S. W., Čadek, M., Codreanu, S. C., Ivić, V., Zomer, C., & Gomoiu, A. (2016). Obesity discrimination in employment recruitment: 'You're not Hired!' *Frontiers in Psychology, 7,* 647.

Flint, S. W., Hudson, J., & Lavallee, D. (2016). The Portrayal of Obesity in U.K. National Newspapers. *Stigma and Health, 1*, 16-28.

Flint, S. W., Hudson, J., & Lavallee, D. (2015). UK adults' implicit and explicit attitudes towards obesity. *BMC Obesity, 2,* 31.

Flint, S. W., Hudson, J., & Lavallee, D. (2013). Counterconditioning as an intervention to modify anti-fat attitudes. *Health Psychology Research, 1*, 122-125.

Flint, S. W., & Snook, J. (2015). Obesity discrimination in the workplace: implementation of recent EU laws. *Current Obesity Reports*, *4*, 504-509.

Flint, S. W., & Snook, J. (2014). Obesity and Discrimination: The Next 'Big Issue'? *International Journal of Discrimination and Law*, *14*, 183-193.

Fredman, S. (2011). Discrimination Law. Oxford: Oxford University Press.

Glatzel v Freistaat Bayern (2014) Case C-356/12.

Goodwin v Patent Office (1999) ICR 302.

Gilmore, N., & Somerville, M. A. (1994). Stigmatization, scapegoating and discrimination in sexually transmitted disease: Overcoming the "them" and "us". *Social Science and Medicine, 39*, 1339–1358.

Goffman, E (1963). *Stigma notes on the management of spoiled identity*. Harmondsworth: Penguin.

Hervey, T., & Rostant, P. (2016). All about that Bass? Is non-ideal weight discrimination unlawful in the UK? *The Modern Law Review*, *79*(2), 248-282.

HK Damark, acting on behalf of Ring v Dansk Almennyttigt Boligselskab; HK Damark, acting on behalf of Werege v Dansk Arbejdsgiverforening, acting on behalf of Pro Display A/S. 2013. Cases C-335/11 and 337/11.

Hochberg, M. C., Lethbridge-Cejku, M., Scott, W. W. Jr, Reichle, R., Plato, C. C., & Tobin, J. D. (1995). The association of body weight, body fatness and body fat distribution with osteoarthritis of the knee: data from the Baltimore Longitudinal Study of Aging. *Journal of Rheumatology*, *22*, 488–493.

Hopkins, K. (2015). KATIE HOPKINS: This Christmas give a fat person you know the greatest gift of all - some brutal honesty! Mail Online.

http://www.dailymail.co.uk/news/article-3364239/KATIE-HOPKINS-Christmas-fat-person-know-greatest-gift-brutal-honesty.html [Accessed 24 May 2016].

Hubert, H, B., Feinleib, M., McNamara, P. M., & Castelli, W. P. (1983).Obesity as an independent risk factor for cardiovascular disease: a 26-year follow-up of participants in the Framingham Heart Study. *Circulation*, *67*, 968–977.

I. B. v Greece. (2013). European Court of Human Rights, application 552-10.

Kippist, L. (2013). News.com.au. http://www.news.com.au/lifestyle/health/fat-people-are-like-dole-bludgers/story-fneuz9ev-1226615873404 [Accessed 24 May 2016].

Larsson, B., Bjorntorp, P., & Tibblin, G. (1981).The health consequences of moderate obesity. *International Journal of Obesity*, *5*, 97–116.

Lawson, A. (2011). Disability and Employment in the Equality Act 2010: Opportunities Seized, Lost and Generated. *Industrial Law Journal*, *40*, 359-383

Lew, E. A., & Garfinkel, L. (1979). Variations in mortality by weight among 750,000 men and women. Journal of Chronic Diseases, *32*, 563–576.

Longo, M. B., Sprose, J. A., & Locke, A. M. (1990). Identifying major concerns of persons with Acquired Immunodeficiency Syndrome: A replication. *Clinical Nurse Specialist*, *4*, 21–26

Mak, W. W., Poon, C. Y., Pun, L. Y., Cheung, S. F. (2007). Meta-analyssi of stigma and mental health. *Social Science and Medicine*, *65*, 2450-261.

Maharjan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Sawires, S. R., Ortiz, D. J., Szekeres, G., & Coates, T. JK. (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS*, *22*, S67-79.

McTigue, P. (2015). 'From Navas to Karltoft: The European Court of Justice's evolving definition of disability and the implications for HIV positive individuals'. *International Journal of Discrimination and Law*, *15*, 241-255

Millman, R. P., Carlisle, C. C., McGarvey, S. T., Eveloff, S. E., & Levinson, P. D. (1995). Body fat distribution and sleep apnea severity in women. *Chest*, *107*, 362–366.

Murphy, P., Hevey, D., O'Dea, S., Ní Rathaille, N., & Mulcahy, F. (2015). Serostatus Disclosure, Stigma Resistance, and Identity Management Among HIV-Positive Gay Men in Ireland. *Qualitative Health Research*, *9*, 1-14. [Published Online Ahead of Print].

Oliver, M. (1996). *Understanding Disability: From Theory to Practice*. Hampshire: Palgrave.

Pelella, F. J., Delany, K. M., Moorman, A. C., Loveless, M. O., Furhrer, J., Satten, G. A., & Holmberg, S. D.(1998). Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection in HIV Outpatient Study Investigators. *New England Journal of Medicine*, *338*, 853-60.

Pâris-Bobozy, M. L. (2014). Paving the Way: Adjustments of Systems and Mutual Influences between the European Court of Human Rights and European Union Law Before Accession. *Irish Jurist*, *51*, 59-89.

Parsons, T. (1958). Definitions of Health and Illness in Light of American Values and Social Structure in Patients. In Jaco, E. F. (Ed.). *Physicians and Illnesses*. New York: The Free Press (pp. 165-168).

Puhl, R. M., & Brownell, K. D. (2001). Bias, discrimination and obesity. *Obesity Research*, *9*, 788–805.

Rodkjaer, L., Sodemann, M., Ostergaard, L., & Lomborg, K. (2011). Disclosure decisions: HIV-positive persons coping with disease-related stressors. *Qualitative Health Research*, *21*, 1249–1259.

Samji, H, Cescon, A., Hogg, R. S., Modur, S. P., Althoff, K. N., Buchacz, K. et al. (2013). Closing the Gap: Increases in Life Expectancy among Treated HIV-Positive Individuals in the United States and Canada. *PLoS ONE*, *8*(12), e81355.

Sargeant, M. (2008). Older Workers and the need for reasonable accommodation. *International Journal of Discrimination and the Law, 9*, 163-180.

Seacat, J., Hirschman, R., & Mickelson, K. D. (2007). Attributions of HIV onset controllability, emotional reactions, and helping intentions: implicit effects of victim sexual orientation. *Journal of Applied Social Psychology*, *37*, 1442-1461.

Shepard, J. W. Jr. (1992). Hypertension, cardiac arrhythmias, myocardial infarction, and stroke in relation to obstructive sleep apnea. *Clinics in Chest Medicine, 13*, 437–458.

Smit, P. J., Brady, M., Carter, M.,. Fernandes, R., Lamore, L., Meulbroek, M. et al. (2012). HIV-related stigma within communities of gay men: A literature review. *AIDS Care, 24*, 405–412.

Society of Professional Journalists. (2010). *Code of Ethics*. http://www.spj.org. [Last accessed on 01 February 2016].

Stamler, R., Stamler, J., Riedlinger, W. F., Algera, G., & Roberts, R. H. (1978). Weight and blood pressure. Findings in hypertension screening of 1 million Americans. *JAMA, 240*,1607–1610.

Sterne, J. A., Hermán, M. A., Ledergerber, B., Tilling, K., Weber, R., Sendi, P. et al. (2005). Long-term effectiveness of potent antiretroviral therapy in preventing AIDS and death: a prospective cohort study. *The Lancet, 366*, 378-384.

Taylor A. (2011). HIV monster. The Sun. http://www.thesun.co.uk/sol/homepage/news/3714448/HIV-monster-Nkosinati-Mabanda-gets-four-years-jail.html [Accessed 24 May 2016].

UPIAS. (1976), *Fundamental Principles of Disability*. London: Union of the Physically Impaired against Segregation.

Waddington, L. (2015) Fine-tuning non-discrimination law: Exceptions and justifications allowing for differential treatment on the ground of disability. *International Journal of Discrimination and the Law, 15,* 11-37.

Walker v Sita Information Networking Computing Ltd [2013] Eq. L.R. 476.

Walker, S. P., Rimm, E. B., Ascherio, A., Kawachi, I., Stampfer, M. J., & Willett, W. C. (1996). Body size and fat distribution as predictors of stroke among US men. *American Journal of Epidemiology, 144*, 1143–1150.

Ware, J. (2016). 'I'm not in the frame of mind to lose weight': Obese husband who is 'too fat to work' pleads for taxpayers to stump up for a £10,000 gastric band operation after piling nine stone back on. Mail Online. http://www.dailymail.co.uk/news/article-3568024/Obese-Steve-Beard-fat-work-pleads-NHS-10-000-gastric-band-operation-piling-nine-stone-on.html [Accessed 24 May 2016].

Watt, B (1996). *Discrimination Law: Concepts, Limitations and Justifications*. Harlow: Longman.

Wells, T. (2011). Stabbed cops given HIV tests. The Sun. http://www.thesun.co.uk/sol/homepage/news/3948113/Stabbed-cops-given-HIV-tests.html [Accessed 24 May 2016].

Westlund, K., & Nicolaysen, R. (1972). Ten-year mortality and morbidity related to serum cholesterol. A follow-up of 3,751 men aged 40–49. *Scandinavian Journal of Clinical and Laboratory Investigation, 127*, 1–24.

World Health Organization (2015). Obesity and overweight. http://www.who.int/mediacentre/factsheets/fs311/en/. [Last accessed on 01 May 2016].

Weiner, B. (1995). *Judgements of responsibility: A foundation for a theory of social conduct*. New York: The Guilford Press.

Woodhams, C., & Corby, S. (2003). Defining Disability in Theory and Practice: A Critique of the British Disability Discrimination Act 1995. *Journal of Social Policy*, *32*, 2, 159-178.

Young, T., Palta, M., Dempsey, J., Skatrud, J., Weber, S., & Badr, S. (1993). The occurrence of sleep-disordered breathing among middle-aged adults. *New England Journal of Medicine*, *328*, 1230–1235.

Z. v A Government Department and The Board of management of a community school (2013) EUECJ C-363/12.