Racial and ethnic minorities already experience disproportionately high rates of type 2 diabetes (T2D) and its complications, a disparity stemming from factors like comorbidities, socioeconomic status, healthcare access, and environmental exposures (e.g., overcrowded housing, essential worker roles, inadequate insurance). Pre-pandemic, disparities in diabetes care and outcomes, especially glycemic control and complication development, were evident (5). The COVID-19 pandemic dramatically worsened this, nearly tripling the annualized incidence of youth-onset T2D in the US, with a 61% increase in new cases between the first and second pandemic years (3). This surge was most pronounced among younger patients (mean age at diagnosis dropped from 14.8 years pre-pandemic to 12.9 years in the first pandemic year; P0.001), with increased severe presentations like diabetic ketoacidosis and hyperglycemic hyperosmolar syndrome (3). Disparities widened further: Black youth showed significantly worse glycemic control and obesity compared to White youth (relative risk ratio [RRR] 3.0; 95% CI 1.3–6.8), and adolescents from the most deprived neighborhoods had higher rates of stable obesity and poor glycemic control (RRR ADI tertile 3 vs. 1: 1.9; 95% CI 1.2–2.9) (6). The pandemic's indirect effects—healthcare disruptions, reduced access to resources, and increased socioeconomic stressors—exacerbated pre-existing inequities, disproportionately harming minority youth with T2D (5–6, 9). While detailed Asia-Pacific data is absent, US evidence strongly indicates a pandemic-related surge in pediatric T2D, particularly affecting racial/ethnic minorities and those experiencing socioeconomic deprivation (3–6).