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Treadmill training and body weight support for walking after stroke (Review)

Mehrholz J, Thomas S, Elsner B

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[Intervention Review]

Treadmill training and body weight support for walking after stroke

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ABSTRACT

Background

Treadmill training, with or without body weight support using a harness, is used in rehabilitation and might help to improve walking after stroke. This is an update of the Cochrane review first published in 2003 and updated in 2005 and 2014.

Objectives

To determine if treadmill training and body weight support, individually or in combination, improve walking ability, quality of life, activities of daily living, dependency or death, and institutionalisation or death, compared with other physiotherapy gait-training interventions after stroke. The secondary objective was to determine the safety and acceptability of this method of gait training.

Search methods

We searched the Cochrane Stroke Group Trials Register (last searched 14 February 2017), the Cochrane Central Register of Controlled Trials (CENTRAL) and the Database of Reviews of Effects (DARE) (the Cochrane Library 2017, Issue 2), MEDLINE (1966 to 14 February 2017), Embase (1980 to 14 February 2017), CINAHL (1982 to 14 February 2017), AMED (1985 to 14 February 2017) and SPORTDiscus (1949 to 14 February 2017). We also handsearched relevant conference proceedings and ongoing trials and research registers, screened reference lists, and contacted trialists to identify further trials.

Selection criteria

Randomised or quasi-randomised controlled and cross-over trials of treadmill training and body weight support, individually or in combination, for the treatment of walking after stroke.

Data collection and analysis

Two review authors independently selected trials, extracted data, and assessed risk of bias and methodological quality. The primary outcomes investigated were walking speed, endurance, and dependency.

Main results

We included 56 trials with 3105 participants in this updated review. The average age of the participants was 60 years, and the studies were carried out in both inpatient and outpatient settings. All participants had at least some walking difficulties and many could not walk without assistance. Overall, the use of treadmill training did not increase the chances of walking independently compared with other physiotherapy interventions (risk difference (RD) -0.00, 95% confidence interval (CI) -0.02 to 0.02; 18 trials, 1210 participants; P = 0.94; I^2 = 0%; low-quality evidence). Overall, the use of treadmill training in walking rehabilitation for people after stroke increased the walking velocity and walking endurance significantly. The pooled mean difference (MD) (random-effects model) for walking velocity was 0.06 m/s (95% CI 0.03 to 0.09;

47 trials, 2323 participants; P < 0.0001; I^2 = 44%; moderate-quality evidence) and the pooled MD for walking endurance was 14.19 metres (95% CI 2.92 to 25.46; 28 trials, 1680 participants; P = 0.01; I^2 = 27%; moderate-quality evidence). Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the walking velocity and walking endurance at the end of scheduled follow-up. The pooled MD (random-effects model) for walking velocity was 0.03 m/s (95% CI -0.05 to 0.10; 12 trials, 954 participants; P = 0.50; I^2 = 55%; low-quality evidence) and the pooled MD for walking endurance was 21.64 metres (95% CI -4.70 to 47.98; 10 trials, 882 participants; P = 0.11; I^2 = 47%; low-quality evidence). In 38 studies with a total of 1571 participants who were independent in walking at study onset, the use of treadmill training increased the walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.08 m/s (95% CI 0.05 to 0.12; P < 0.00001; I^2 = 49%). There were insufficient data to comment on any effects on quality of life or activities of daily living. Adverse events and dropouts did not occur more frequently in people receiving treadmill training and these were not judged to be clinically serious events.

Authors' conclusions

Overall, people after stroke who receive treadmill training, with or without body weight support, are not more likely to improve their ability to walk independently compared with people after stroke not receiving treadmill training, but walking speed and walking endurance may improve slightly in the short term. Specifically, people with stroke who are able to walk (but not people who are dependent in walking at start of treatment) appear to benefit most from this type of intervention with regard to walking speed and walking endurance. This review did not find, however, that improvements in walking speed and endurance may have persisting beneficial effects. Further research should specifically investigate the effects of different frequencies, durations, or intensities (in terms of speed increments and inclination) of treadmill training, as well as the use of handrails, in ambulatory participants, but not in dependent walkers.

PLAIN LANGUAGE SUMMARY

Treadmill training and body weight support for walking after stroke

Review question: We wanted to assess whether walking practice on a treadmill with the body being supported by a harness as the only form of training versus in combination with other kinds of training, could improve walking when compared with other training methods for walking or no treatment. This is an update of the Cochrane review first published in 2003 and updated in 2005 and 2014.

Background: About 60% of people who have had a stroke have difficulties with walking, and improving walking is one of the main goals of rehabilitation. Treadmill training, with or without body weight support, uses specialist equipment to assist walking practice.

Study characteristics: We identified 56 relevant trials, involving 3105 participants, up to March 2017. Twenty-six studies (1410 participants) compared treadmill training with body weight support to another physiotherapy treatment; 20 studies (889 participants) compared treadmill training without body weight support to other physiotherapy treatment, no treatment, or sham treatment; two studies (100 participants) compared treadmill training with body weight support to treadmill training without body weight support; and four studies (147 participants) did not state whether they used body weight support or not. The average age of the participants was 60 years, and the studies were carried out in both inpatient and outpatient settings.

Key results: The results of this review were partly inconclusive. People after stroke who receive treadmill training with or without body weight support are not more likely to improve their ability to walk independently. The quality of this evidence was low. However, treadmill training with or without body weight support may improve walking speed and walking capacity compared with people not receiving treadmill training. The quality of this evidence was moderate. More specifically, people after stroke who are able to walk at the start of therapy appear to benefit most from this type of intervention, but people who are not able to walk independently at therapy onset do not benefit. This review found that improvements in walking speed and endurance in people who can walk have no lasting positive effect. Unwanted events such as falls and dropouts were not more common in people receiving treadmill training.

Further analysis showed that treadmill training in the first three months after stroke produces only modest improvements in walking speed and endurance. For people treated at a later stage (more than six months after their stroke) the effects were smaller. More frequent treadmill training (for example, five times per week) appears to produce greater effects on walking speed and endurance; however, this was not conclusive. Brief periods of treadmill training (duration of four weeks) provided a modest improvement in walking speed but not enough to be clinically important.

Effects of the age of participants or the type of stroke were not investigated in this review.

In practice, it appears that people who can walk after stroke, but not those who cannot, may profit from treadmill training (with and without body weight support) to improve their walking abilities. Further research should specifically investigate the effects of different frequencies, durations or intensities (in terms of speed increments and inclination) of treadmill training, as well as the use of handrails. Future trials should include people who can already walk, but not dependent walkers who are unable to walk unaided. Future research should analyse age groups, gender, and type of stroke to see who might benefit most from this treatment.

Quality of the evidence

The quality of evidence for treadmill training for walking after stroke was low to moderate. It was moderate for walking speed and walking endurance at the end of treatment and low for improving the ability to walk independently.

SUMMARY OF FINDINGS

Summary of findings for the main comparison. Treadmill (with or without body weight support) versus other intervention for walking after stroke

Treadmill (with or without body weight support) versus other intervention for walking after stroke

Patient or population: adults who had suffered a stroke and exhibited an abnormal gait pattern
Settings: inpatient and outpatient setting
Intervention: treadmill (with or without body weight support) versus other intervention

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Quality of the evidence (GRADE)	Comments
	Assumed risk	Corresponding risk				
	Control	Treadmill (with or without body weight support) versus other intervention				
Dropouts - by end of treatment Numbers of dropouts and adverse events	**Study population**		See comment	3105 (56 studies)	⊕⊕⊖⊖ **low** [1]	Risks were calculated from pooled risk differences
	91 per 1000	**93 per 1000** (81 to 101)				
	Moderate					
	31 per 1000	**32 per 1000** (28 to 34)				
Walking speed (m/s) at end of treatment timed measures of gait	The mean walking speed (m/s) at end of treatment in the control groups was **0.48 m/s**	The mean walking speed (m/s) at end of treatment in the intervention groups was **0.06 higher** (0.03 to 0.09 higher)		2323 (47 studies)	⊕⊕⊕⊖ **moderate** [1,2,3]	
Walking speed (m/s) at end of treatment - dependent in walking at start of treatment timed measures of gait	The mean walking speed (m/s) at end of treatment - dependent in walking at start of treatment in the control groups was **0.32 m/s**	The mean walking speed (m/s) at end of treatment - dependent in walking at start of treatment in the intervention groups was **0.01 lower** (0.06 lower to 0.03 higher)		752 (9 studies)	⊕⊕⊖⊖ **low** [1,2]	
Walking speed (m/s) at end of treatment - in-	The mean walking speed (m/s) at end of treatment - independent in walking	The mean walking speed (m/s) at end of treatment - independent in		1571 (38 studies)	⊕⊕⊖⊖ **low** [1,2]	

dependent in walking at start of treatment timed measures of gait	at start of treatment in the control groups was **0.64 m/s**	walking at start of treatment in the intervention groups was **0.09 higher** (0.05 to 0.12 higher)			
Walking endurance (m) at end of treatment timed measures of gait	The mean walking endurance (m) at end of treatment in the control groups was **177 m**	The mean walking endurance (m) at end of treatment in the intervention groups was **14.19 higher** (2.92 to 25.46 higher)		1680 (28 studies)	⊕⊕⊕⊖ **moderate** [1,2,3]
Walking endurance (m) at end of treatment - dependent in walking at start of treatment timed measures of gait	The mean walking endurance (m) at end of treatment - dependent in walking at start of treatment in the control groups was **115 m**	The mean walking endurance (m) at end of treatment - dependent in walking at start of treatment in the intervention groups was **5.09 lower** (23.41 lower to 13.22 higher)		639 (5 studies)	⊕⊕⊖⊖ **low** [1,2]
Walking endurance (m) at end of treatment - independent in walking at start of treatment timed measures of gait	The mean walking endurance (m) at end of treatment - independent in walking at start of treatment in the control groups was **240 m**	The mean walking endurance (m) at end of treatment - independent in walking at start of treatment in the intervention groups was **19.72 higher** (6.61 to 32.83 higher)		1041 (23 studies)	⊕⊕⊖⊖ **low** [1,2]

*The basis for the **assumed risk** (e.g. the median control group risk across studies) is provided in footnotes. The **corresponding risk** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).
CI: Confidence interval; **RR:** Risk ratio;

GRADE Working Group grades of evidence
High quality: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low quality: We are very uncertain about the estimate.

[1] Downgraded because 95% CI contains effect size of no difference and the minimal important difference.
[2] Downgraded due to several ratings with 'high' or 'unclear' risk of bias
[3] Upgraded due to evidence of a dose-response gradient

BACKGROUND

Description of the condition

Stroke ranks as the sixth highest cause of burden of disease worldwide in terms of disability adjusted life years and is the single most important cause of severe disability in people living in their own homes (Murray 2012). An inability or an impaired ability to walk is a significant contributor to long-term disability and burden of care after stroke. Approximately one-third of people surviving acute stroke are unable to walk three months after admission to a general hospital (Langhorne 2009).

High-quality evidence from systematic reviews indicates that organised (stroke unit) care decreases physical dependence after stroke compared with general medical care (SUTC 2013). This organised care is characterised by early mobilisation and multidisciplinary rehabilitation (including physiotherapy) co-ordinated by regular team meetings (Langhorne 2002). The effectiveness of specific physiotherapy gait-training strategies, however, is still not very clear. A review of studies comparing different physiotherapy treatments for participants with stroke concluded that "There is insufficient evidence to conclude that any one physiotherapy approach is more effective in promoting recovery of lower limb function or postural control following stroke than any other approach." (Pollock 2014).

Description of the intervention

Walking on a treadmill, with or without body weight supported via a harness connected to an overhead support system, is a method of treating walking impairments post-stroke that is becoming increasingly popular. Use of a treadmill permits a greater number of steps to be performed within a training session; that is, it increases the amount of task-specific practice completed. For example, Hesse 2003 reported that people after stroke can perform up to 1000 steps in a 20-minute treadmill training session, compared with only 50 to 100 steps during a 20-minute session of conventional physiotherapy (neurophysiological approach). The speed of the treadmill, the amount of body weight support, and the amount of assistance provided by the physiotherapist can all be adjusted in order to provide a sufficient training intensity. This intervention emerged from research involving spinalised cats (Barbeau 1987) and was first used in clinical settings in the 1980s (Finch 1985). Since then, treadmill training with partial body weight support has been increasingly promoted as a treatment to drive recovery after stroke (Charalambous 2013; Langhorne 2009).

Treadmill training with body weight support is costly in terms of equipment and human resources. In addition, the equipment is not portable, so stroke participants must attend a suitably equipped healthcare facility in order to access this treatment. Several published randomised controlled trials (RCTs) have evaluated treadmill training with or without body weight support (Charalambous 2013; Polese 2013).

How the intervention might work

Improving walking after stroke is one of the main goals of rehabilitation. There is increasing evidence that high-intensity, repetitive, task-specific training might result in better gait rehabilitation (French 2016; Langhorne 2009). One example of potentially intensive, repetitive, task-specific gait-training is treadmill training. Treadmill training can be used to give patients intensive practice (in terms of high repetitions) of complex gait cycles and is being used as a method for increasing walking speed and walking distance in people who had a stroke. The advantage of treadmill training, compared with walking training overground, may be that higher walking speeds and a higher number of gait cycles can be achieved. Treadmill training, therefore, might be effective at improving walking parameters such as gait speed and walking distance after stroke (Polese 2013).

Why it is important to do this review

Several non-Cochrane systematic reviews evaluating treadmill training, with and without body weight support, have been published since this Cochrane review first appeared in the Cochrane Library 2003, Issue 3 (e.g. Manning 2003; Teasell 2003; Van Peppen 2004) and more recently updates during 2013 (Charalambous 2013; Polese 2013). However, all of these reviews are now out of date or had some methodological weaknesses (e.g. they did not used a comprehensive search strategy for all relevant databases or were prone to language bias because non-English studies were not included).

Updating this Cochrane review is required in order to justify the large equipment and human resource cost required to implement treadmill training, as well as to confirm the safety and acceptance of this method of training. The first update of this review was published in 2005 and included 15 trials with 622 participants; the second update was published in 2014 and included already 44 trials with 2658 participants. This is the third update of this Cochrane review. The search for trials was extended from June 2013 to March 2017. The aim of this review is to provide an update of the best available evidence about the above-mentioned approach.

OBJECTIVES

To determine if treadmill training and body weight support, individually or in combination, improve walking ability, quality of life, activities of daily living, dependency or death, and institutionalisation or death, compared with other physiotherapy gait-training interventions after stroke. The secondary objective was to determine the safety and acceptability of this method of gait-training.

METHODS

Criteria for considering studies for this review

Types of studies

We included truly randomised and quasi-randomised controlled trials (including cross-over trials) in the review. We considered procedures such as coin tossing and dice rolling as random. Quasi-random allocation procedures included allocation by hospital record number or birth date, or alternation. We only included the first arm of the data from cross-over trials. We assessed concealment, blinding, and the number of withdrawals for all trials, but we did not use these data as inclusion or exclusion criteria.

Treadmill training and body weight support, individually or in combination, must have been implemented in one of the experimental conditions. We were looking for trials that made one of the following comparisons:

- treadmill training with body weight support versus other physiotherapy, placebo, or no intervention;
- treadmill training without body weight support versus other physiotherapy, placebo, or no intervention;
- treadmill training with body weight support versus treadmill training without body weight support; and
- body weight support (without treadmill training) versus other physiotherapy, placebo, or no intervention.

Treadmill training and body weight support, individually or in combination, may have been implemented with physiotherapy co-intervention(s). Where co-intervention(s) were comparable for experimental and control groups, we grouped the trials according to the first four comparisons. In some cases, however, the co-intervention(s) used were not the same for the treatment and control groups. For example, treadmill training with body weight support may be implemented as one component of a task-oriented physiotherapy program and compared with non task-oriented physiotherapy (Richards 1993). Task-oriented physiotherapy programs involve task and context-specific training of motor skills based on a movement science or motor relearning framework (Carr 1998). Non-task-oriented physiotherapy includes neurophysiological approaches to treatment, such as Bobath (Bobath 1990), Brunnstrom (Brunnstrom 1970), Rood (Goff 1969) and proprioceptive neuromuscular facilitation (Knott 1968). While these trials cannot differentiate the effects of treadmill training and body weight support from other co-interventions, they do evaluate the intervention as part of a treatment package. We identified such trials and described them separately.

We included trials that evaluated any intensity and duration of treadmill training and body weight support that exceeded a single treatment session. Where necessary, we obtained details of the treatment and control interventions via correspondence with the trialists.

Types of participants

We included trials of adults who had suffered a stroke and exhibited an abnormal gait pattern. We used the World Health Organization's (WHO) definition of stroke: "rapidly developing clinical signs of focal (at times global) disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than that of vascular origin." (Hatano 1976). We defined an abnormal gait pattern as walking with a slow speed, exhibiting kinematic deviations during gait (Moore 1993; Moseley 1993), or an inability to walk.

We envisaged that some trials may have included participants with other types of upper motor neurone lesions (e.g. traumatic brain injury, multiple sclerosis). However, we did not identify any mixed trials. If we identify trials using mixed types of participants in future updates of this review, we will attempt to obtain data for the stroke subgroup only via correspondence with the trialists.

Types of interventions

The primary question was whether treadmill training and body weight support, individually or in combination, could improve walking compared with other gait-training methods, placebo or no treatment. We therefore included any trial that attempted to evaluate such a comparison. Treadmill training involves walking on a standard treadmill; assistance, feedback or guidance may be provided by a health professional (usually a physiotherapist). Some of the participant's body weight may be supported during this training using a harness attached to an overhead support system. Alternatively, this type of body weight support can be used without a treadmill.

Types of outcome measures

Primary outcomes

The primary analyses focused on the ability to walk, both at the end of the treatment period (that is, immediate or short-term effects) and at the end of the scheduled follow-up (that is, long-term effects). We examined the ability to walk using dichotomous and continuous variables.

The dichotomous variable was 'dependence on personal assistance', where we defined 'dependence' as the inability to walk indoors (with or without a gait aid) without personal assistance or supervision. If reported, we used data from functional scales (or parts of functional scales relating to walking) to define the level of dependence. Suitable scales (with criterion for 'dependence') are:

- Motor Assessment Scale (Carr 1985), a score of two or less;
- Functional Independence Measure (Hamilton 1994), a score of five or less for the walking item;
- Barthel Index (Collin 1988), a score of three (independent, but may use any aid) or less for the ambulation item;
- Rivermead Mobility Index (Collen 1991), an answer of 'no' to the 'walking inside, with an aid if necessary' item; and
- Functional Ambulation Category (Holden 1984), a score of two or less.

We used walking dependence at the start of treatment to group trials in each comparison in the analyses.

The continuous variables were:

- independent walking speed measured over a short distance (e.g. six to 10 metres); and
- independent walking endurance measured over a long distance (e.g. Six-Minute Walk Test) expressed as a total distance walked.

These tests could be performed with or without a gait aid, but must have been completed without personal assistance. Wade 1992 reported that independent walking speed over a short distance is a simple, reliable, valid, and sensitive measure of walking performance. Walking over a long distance is a valid (Wade 1992) and reliable (Guyatt 1984) measure of walking endurance with established reference equations (Enright 1998). Where participants could not walk unless assisted, we allocated a speed and distance score of zero.

Secondary outcomes

Secondary outcome measures included participant quality of life, ability to perform activities of daily living, and the combined outcomes of death or dependency, and death or institutional care. Quality of life scales included the Frenchay Activities Index, Medical Outcomes Study Short Form Health Survey Questionnaire, Nottingham Health Profile, Quality of Life Index and Sickness Impact Profile (De Haan 1993).

Activities of daily living scales included the Barthel Index, Modified Rankin Scale and Nottingham Extended Activities of Daily Living Scale (Wade 1992); and the Index of Activities of Daily Living, Instrumental Activities of Daily Living Scale, Functional Activities Questionnaire, and Blessed Functional Activities Scale (Pohjasvaara 1997).

We used the Stroke Unit Trialists' Collaboration definitions for death or dependency and death or institutional care (SUTC 2013). The criterion for dependency is scoring less than 18 on the Barthel Index or greater than two on the Modified Rankin Scale, while institutional care refers to care in a residential home, nursing home, or hospital at the end of the scheduled follow-up.

We determined the safety and acceptance of treadmill training. We used the prevalence of adverse events during the treatment period as a measure of safety. We categorised adverse events into injurious falls, other injury, major cardiovascular events, and any other adverse outcomes. We examined the reason for participants withdrawing from the studies as a marker for acceptance. We analysed these withdrawal data qualitatively.

Search methods for identification of studies

See the 'Specialized register' section in the Cochrane Stroke Group module. For this update, we extended the search for trials from March 2005 (when the first update of this review was published) to 14 February 2017. We searched for trials in all languages and arranged translation of relevant trial reports published in languages other then English.

Electronic searches

We searched the Cochrane Stroke Group Trials Register (last searched 14 February 2017) and the following electronic bibliographic databases:

- Cochrane Central Register of Controlled Trials (CENTRAL; 2017, Issue 4) in the Cochrane Library (searched 10 April 2017) (Appendix 1);
- MEDLINE Ovid (1966 to 14 February 2017) (Appendix 2);
- Embase Ovid (1980 to 14 February 2017) (Appendix 3);
- CINAHL EBSCO (Cumulative Index to Nursing and Allied Health Literature; 1982 to 14 February 2017) (Appendix 4);
- AMED Ovid (Allied and Complementary Medicine; 1985 to 14 February 2017) (Appendix 5); and
- SPORTDiscus EBSCO (1949 to 14 February 2017) (Appendix 6).

We developed the search strategies with the help of the Cochrane Information Specialist and adapted the MEDLINE search strategy for the other databases.

We identified and searched the following ongoing trials and research registers:

- International Standard Randomised Controlled Trial Number Register (www.isrctn.com; searched 9 March 2017);
- US National Institutes of Health Ongoing Trials Register ClinicalTrials.gov (www.clinicaltrials.gov; searched 9 March 2017) (Appendix 7);
- Stroke Trials Register (www.strokecenter.org; searched 9 March 2017); and
- World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) (searched 9 March 2017) (Appendix 8).

Searching other resources

We also:

- handsearched the following relevant conference proceedings:
  - World Congress of NeuroRehabilitation (2006 to 2016);
  - World Congress of Physical Medicine and Rehabilitation (2005 to 2015);
  - World Congress of Physical Therapy (2007 to 2015);
  - Deutsche Gesellschaft für Neurotraumatologie und Klinische Neurorehabilitation (2005 to 2016);
  - Deutsche Gesellschaft für Neurologie (2005 to 2016);
  - Deutsche Gesellschaft für Neurorehabilitation (2005 to 2016); and
  - Asian Oceania Conference of Physical and Rehabilitation (2008 to 2016);
- screened reference lists of all relevant articles; and
- contacted trialists, experts, and researchers in our field of study.

Data collection and analysis

Selection of studies

For this update, two review authors (BE and JM) read the titles and abstracts of the records identified from the electronic searches and eliminated obviously irrelevant studies. We retrieved the full texts of the remaining studies and two review authors (BE and JM) ranked the studies as relevant, possibly relevant or irrelevant according to our inclusion criteria (types of studies, participants, aims of interventions). Two review authors (JM, ST) then examined whether the relevant and possibly relevant publications fitted the population, intervention, comparison, outcome (PICO) strategy of our study question. We resolved disagreements by discussion with all authors. If we needed further information, we contacted trial authors.

We excluded studies that did not match our inclusion criteria regarding the type of study, participants or type of interventions and those that were not RCTs.

Data extraction and management

For this update, two review authors (BE, JM) independently extracted trial and outcome data from the selected trials. If one of the review authors was involved in an included trial, another review author extracted the trial and outcome data from that trial. In accordance with the 'Risk of bias' tool described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011), we used checklists to independently assess:

- methods of random sequence generation;
- methods of allocation concealment;
- blinding of assessors;
- blinding of participants;
- adverse effects and dropouts;
- important imbalances in prognostic factors at baseline;
- participants (country, number of participants, age, gender, type of stroke, time from stroke onset to study entry, inclusion

and exclusion criteria, cognition, pre-existing neurological impairment(s), neurological history);
- comparison (details of interventions in treatment and control groups, duration of treatment, details of co-interventions in the groups);
- outcomes and their time point of measurement.

All review authors checked the extracted data for agreement. If these authors could not reach consensus, a researcher not involved in data extraction arbitrated. If necessary, we contacted the researchers to request more information.

Assessment of risk of bias in included studies

For this update of the review, two authors (BE and JM) independently assessed the risk of bias in the included trials in accordance with the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). We described the agreement between authors during the assessment of risk of bias and we resolved disagreement by reaching consensus through discussion. We contacted trialists for clarification and to request missing information.

Measures of treatment effect

For all outcomes representing continuous data, we entered means and standard deviations. We calculated a pooled estimate of the mean difference (MD) with 95% confidence interval (CI). If studies did not use the same outcome measure, we calculated standardised mean differences (SMD) instead of MDs. For all binary outcomes, we calculated risk differences (RD) with 95% CI. For all analyses, we used Cochrane's Review Manager software, RevMan 5.2 (RevMan 2012) and used a random-effects model.

Unit of analysis issues

In the event that individuals underwent more than one intervention, as in a cross-over trial, we only used data from the first phase of the study before cross-over.

If outcomes were repeatedly observed in participants (e.g. follow-up at four and six weeks), we reported the measures at the longest time point post intervention from each study.

Dealing with missing data

We contacted the relevant principal investigators to retrieve missing data. Where possible, we extracted data to allow an intention-to-treat (ITT) analysis in which all randomised participants were analysed
in the groups to which they were originally assigned. We did not make assumptions about loss to follow-up for continuous data. We analysed results for those who completed the trial.

Assessment of heterogeneity

We used the I^2 statistic to assess hterogeneity. We used a random-effects model, regardless of the level of heterogeneity. Thus, in the case of heterogeneity, we did not violate the preconditions of a fixed-effect model approach.

Assessment of reporting biases

We inspected funnel plots for assessing the risk of publication bias.

Data synthesis

GRADE and 'Summary of findings' table

We created a 'Summary of findings for the main comparison' using the following outcomes.

- Walking speed (m/s) at the end of treatment. Scale from: 0 to infinity.
- Walking speed (m/s) at the end of treatment - dependent in walking at the start of treatment. Scale from: 0 to infinity.
- Walking speed (m/s) at the end of treatment - independent in walking at the start of treatment. Scale from: 0 to infinity.
- Walking endurance (m) at the end of the intervention phase. Scale from: 0 to infinity.
- Walking endurance (m) at the end of treatment - dependent in walking at the start of treatment. Scale from: 0 to infinity.
- Walking endurance (m) at the end of treatment - independent in walking at the start of treatment. Scale from: 0 to infinity.
- Dropouts - by the end of treatment. Numbers of dropouts and adverse events.

We used the eight GRADE considerations (study limitations, consistency of effect, imprecision, indirectness, publication bias, large effect, plausible confounding would change the effect, and dose response gradient) to assess the quality of the body of evidence as it related to the studies which contributed data to the meta-analyses for the prespecified outcomes (Atkins 2004). We used methods and recommendations described in Section 8.5 and Chapter 12 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011) using GRADEpro GDT software (GRADEpro GDT). We justified all decisions to down- or up-grade the quality of studies using footnotes, and we made comments to aid the reader's understanding of the review, where necessary.

Subgroup analysis and investigation of heterogeneity

We did three subgroup analyses:

- for time between the stroke and the start of training (first subgroup defined as in the first 3 months after stroke, second subgroup defined by duration of illness of more than 3 months)
- the intensity of training (subgroups defined by a weekly frequency of 5 times per week, 3 to 4 times a week and 3 times per week or less), and
- the duration of training (subgroups defined by categories of more than 4 weeks, 4 weeks or less than 4 weeks).

The scientific rationale for defining these categories in subgroups is that these above categories were described in the research (e.g. in study protocols for trials assessing the effects of treadmill training) and they are used in clinical rehabilitation after stroke.

However, for the types of co-interventions implemented in conjunction with treadmill training, we were not able to conduct a subgroup analysis.

We conducted subgroup analyses according to whether participants in the trials were dependent or independent walkers.

Sensitivity analysis

We performed a sensitivity analysis based on the mehodological quality of trials (involving treadmill training) including true versus

quasi-randomisation, concealed versus unconcealed allocation, and blinded versus non-blinded outcome assessment.

RESULTS

Description of studies

See: Characteristics of included studies; Characteristics of excluded studies; Characteristics of studies awaiting classification; Characteristics of ongoing studies

Results of the search

2014 version

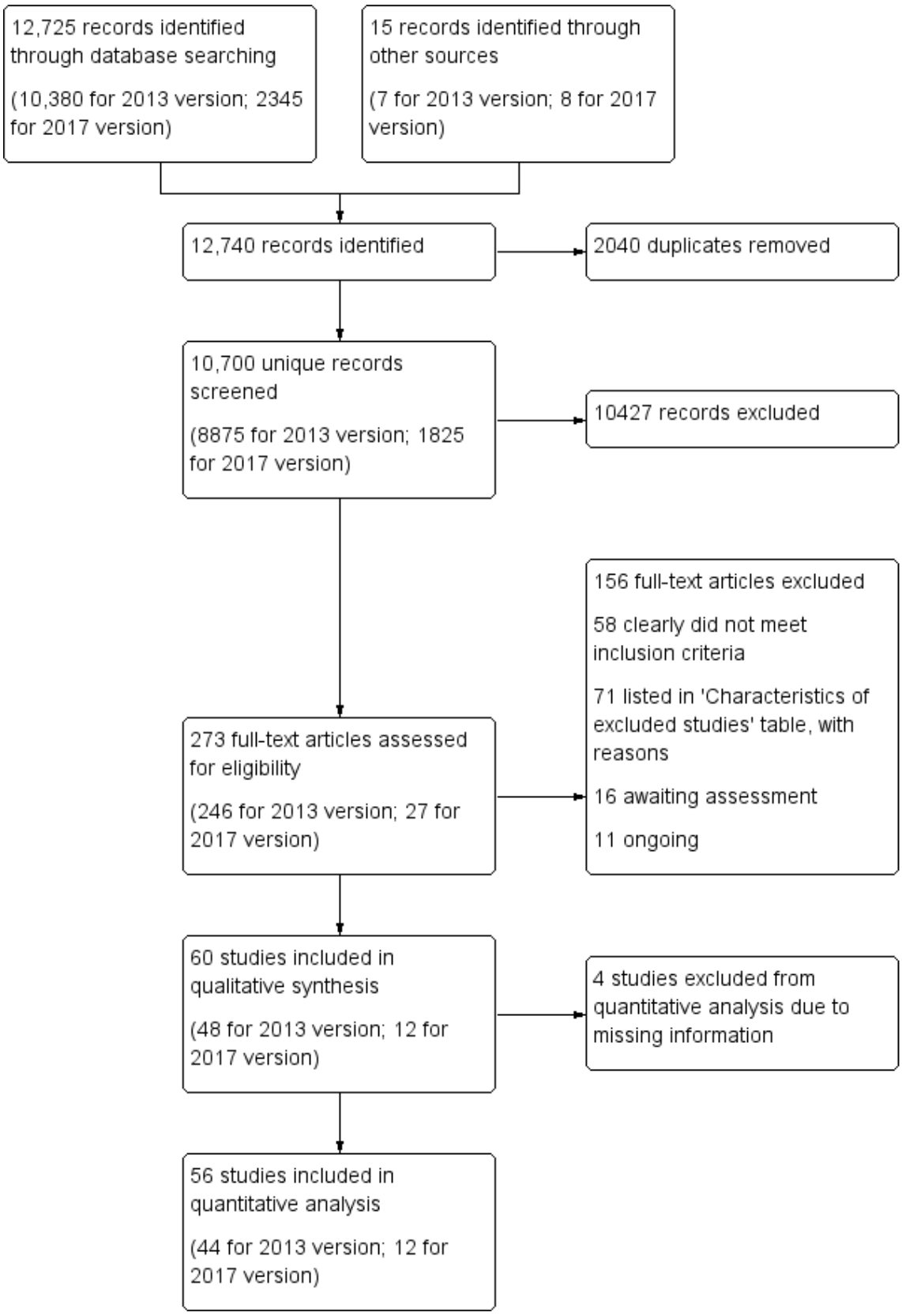
For the 2014 version of this review, we identified 12725 potentially relevant trials through electronic searching; we considered 246 full papers and included 44 trials with 2658 participants (Ada 2003; Ada 2010; Ada 2013; Da Cunha Filho 2002; Deniz 2011; Du 2006; Duncan 2011; Eich 2004; Franceschini 2009; Gan 2012; Globas 2011; Hoyer 2012; Jaffe 2004; Kang 2012; Kim 2011; Kosak 2000; Kuys 2011; Langhammer 2010; Laufer 2001; Liston 2000; Luft 2008; MacKay-Lyons 2013; Macko 2005; Mehrberg 2001; Moore 2010; Nilsson 2001a; Nilsson 2001b; Olawale 2009; Pohl 2002; Richards 1993; Richards 2004; Scheidtmann 1999; Smith 2008; Sullivan 2007; Suputtitada 2004; Takami 2010; Toledano-Zarhi 2011; Visintin 1998a; Visintin 1998b; Weng 2004; Weng 2006; Werner 2002a; Yang 2010; Yen 2008; Zhang 2008; Zhu 2004)

2017 version

In this update, the searches of the electronic databases and trials registers generated 10700 unique references for screening. After excluding nonrelevant citations, we obtained the full texts of 27 papers; of these, we included 12 trials in the qualitative and quantitative analysis of the review (Bonnyaud 2013; Bonnyaud 2013a; Combs-Miller 2014; DePaul 2015; Gama 2017; Kim 2016; Mao 2015; Middleton 2014; Park 2013; Park 2015; Ribeiro 2013; Srivastava 2016).

Figure 1 shows the flow diagram for the selection of studies.

Figure 1. Flow diagram. Please note that the number of full-texts is not necessarily equal to the number of studies that means that there often are several full-texts of a single trial (e.g. as is the case for Ada 2003 or DEGAS 2007).



Included studies

We included 56 studies, involving a total of 3105 participants, in the quantitative analysis of this review (see the Characteristics of included studies). Two included studies have been split up into two sub-studies each (Nilsson 2001; Visintin 1998).

Twenty-six studies (1410 participants) compared treadmill training with body weight support to another physiotherapy intervention (Analysis 2.2); 20 studies (889 participants) compared treadmill training without body weight support to another physiotherapy intervention, no intervention or sham intervention (Analysis 3.1); two studies (100 participants) compared treadmill training with body weight support to treadmill training without body weight support; and four studies (147 participants) did not state whether they used body weight support or not.

No studies compared body weight support without treadmill training to another physiotherapy intervention.

The data from two studies were subdivided for the analyses and the corresponding participants were not double-counted. The Nilsson 2001 and Visintin 1998 studies recruited both dependent and independent walkers, so the data were subdivided into two comparisons for each trial. For the Nilsson 2001 trial, we separately analysed data from the 54 participants (26 experimental and 28 control) who were dependent walkers at the start of treatment (Nilsson 2001a) and data from the 19 participants (10 experimental and nine control) who were independent walkers at the start of treatment (Nilsson 2001b). For the Visintin 1998 trial, we performed separate analyses for data from the 59 participants (33 experimental and 26 control) (Visintin 1998a) and 20 participants (10 experimental and 10 control) (Visintin 1998b) who were dependent and independent walkers at the start of treatment, respectively. We obtained these walking dependency data through correspondence with the authors.

The characteristics of participants in the included studies are listed in Table 1. The characteristics of the experimental interventions are listed in Table 2. The outcomes used in the included studies are described in detail in the Characteristics of included studies. The reporting of adverse events and dropouts was incomplete for all trials and described in detail in Table 3 and Table 4. If these data were not explicitly reported, we attempted to obtain the missing information through correspondence with the trialists.

Excluded studies

We excluded 72 studies for various reasons (see Characteristics of excluded studies). Fivteen studies are still awaiting classification, mainly due to being conference abstracts with sparse outcome data reported and we were unable to contact the authors (see the Characteristics of studies awaiting classification). Eleven studies are ongoing (see the Characteristics of ongoing studies).

We excluded all these studies from the main analysis.

Risk of bias in included studies

Two authors (JM and ST) independently assessed the methodological quality of the included trials using the 'Risk of bias' tool (using the categories random sequence generation, allocation concealment and blinding of outcome assessors; Figure 2).

Figure 2. 'Risk of bias' summary: review authors' judgements about each risk of bias item for each included study.

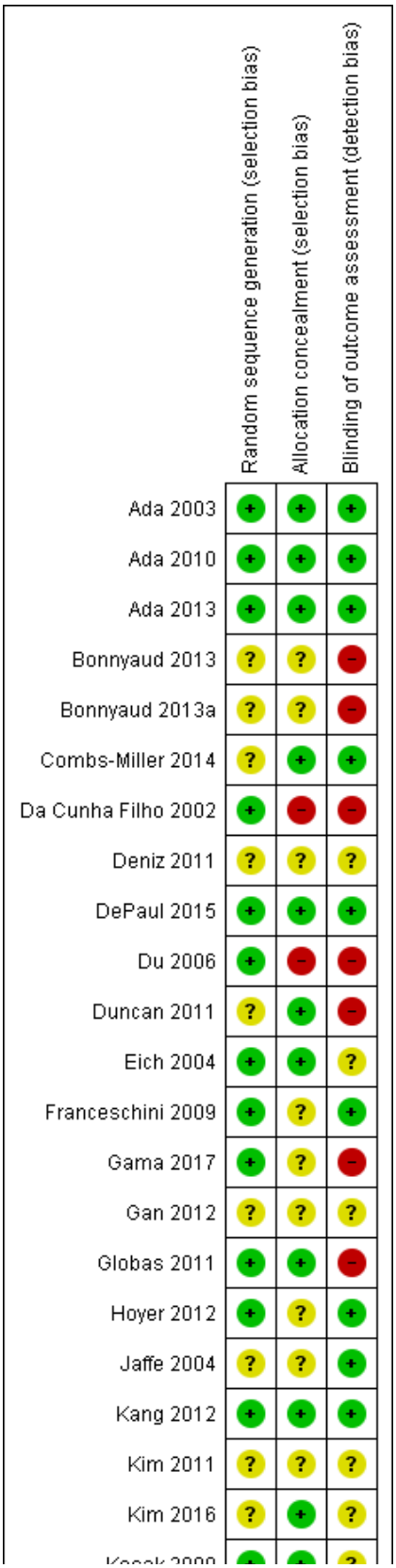


Figure 2. (Continued)

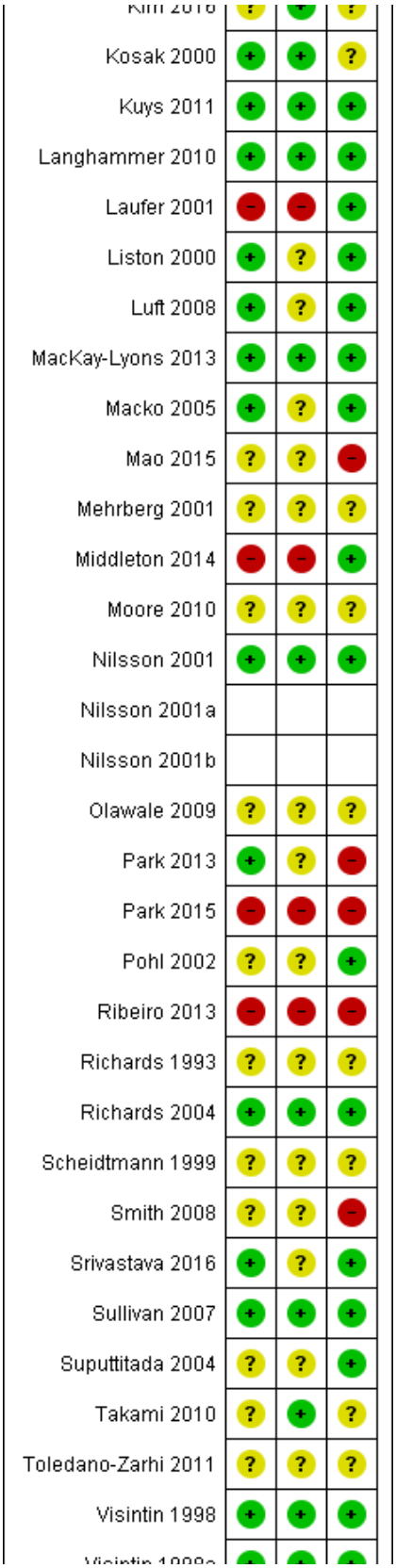
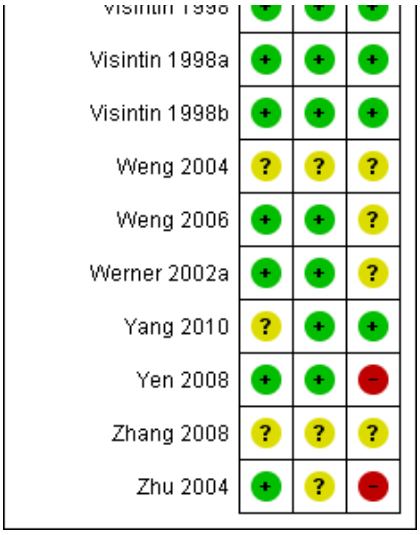


Figure 2. (Continued)



We wrote to all trialists requesting clarification of some design features or the provision of missing information in order to complete the quality ratings (correspondence was via email or letter, with a reminder being send after three weeks and then every three months if we did not get a response). If no data were provided or no contact achieved, we used published data only for all analysis.

Three trials used a cross-over design with random allocation to the order of treatments (Liston 2000; Scheidtmann 1999; Werner 2002a). All other studies used a parallel-group design with true randomisation or quasi-randomisation (Laufer 2001) to groups.

We explored publication bias visually by inspecting funnel plots for all comparisons (plots only shown for analyses 1.1 and 1.2 (Figure 3; Figure 4)). Our inspection did not indicate clear evidence for publication bias or our inspection was not suggestive of systematic heterogeneity. The only systematic heterogeneity in the funnel plots was found between categories of people after stroke who were dependent or independent walkers at study onset (as we described in detail above).

Figure 3. Funnel plot of comparison: 1 Treadmill (with or without body weight support) versus other intervention, outcome: 1.1 Walking speed (m/s) at end of treatment.

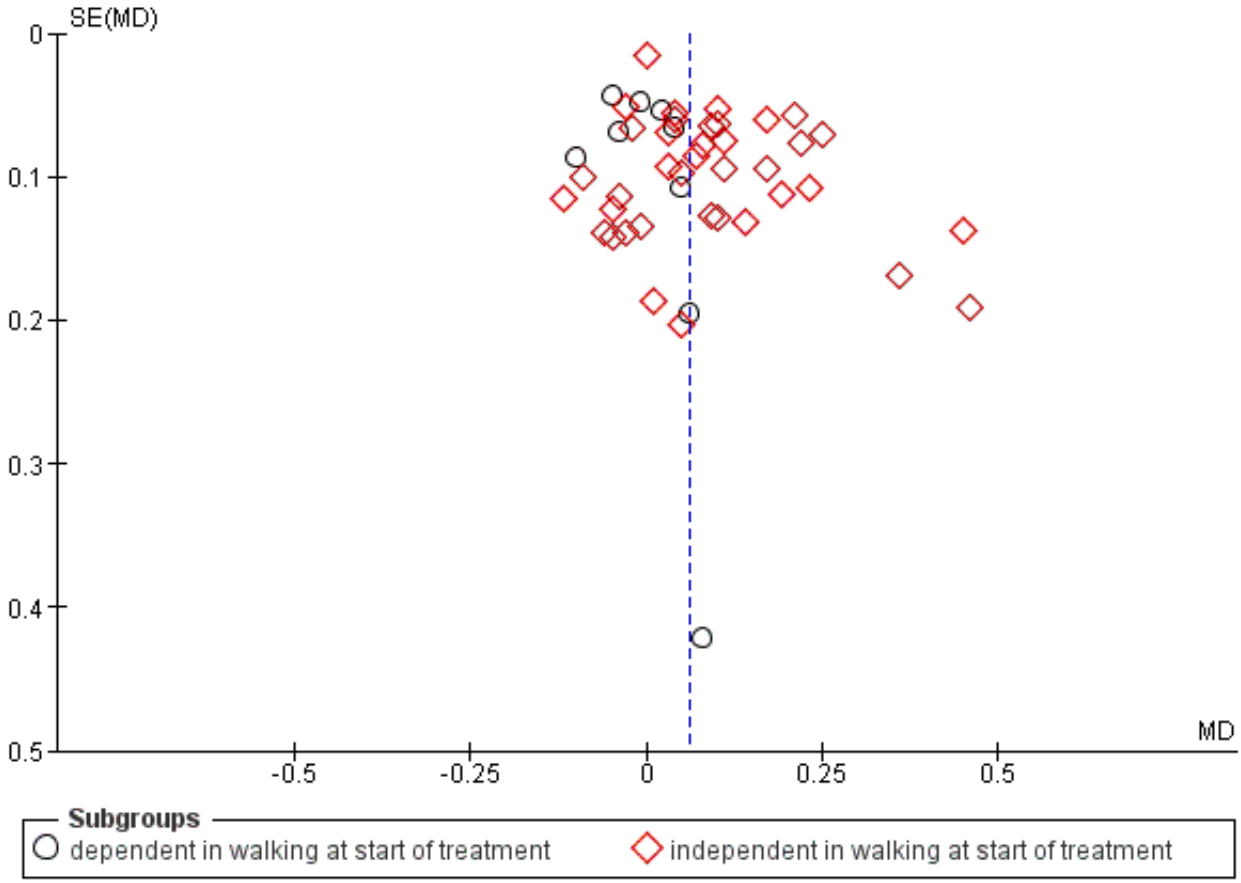
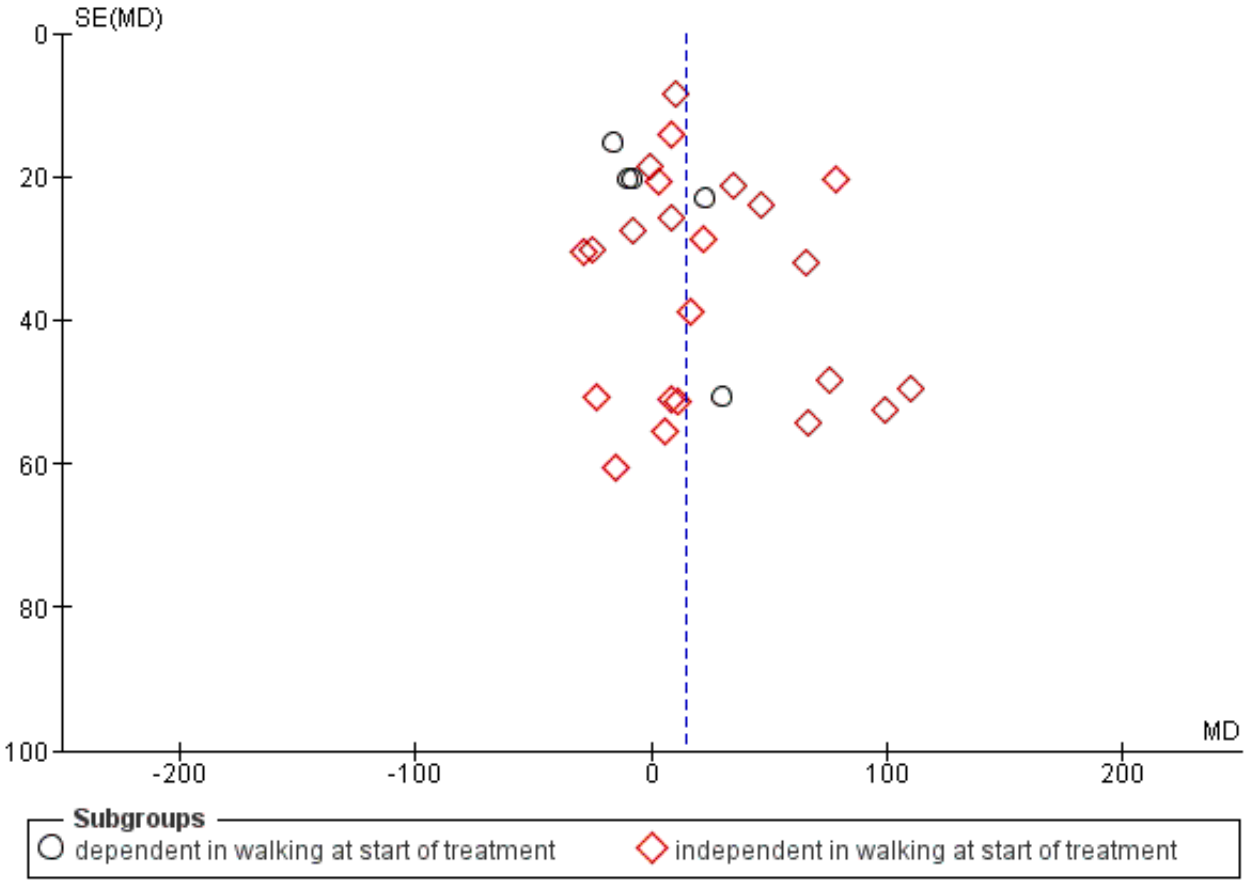


Figure 4. Funnel plot of comparison: 1 Treadmill (with or without body weight support) versus other intervention, outcome: 1.2 Walking endurance (m) at end of treatment.



Allocation

Twenty-nine of the 56 included studies described appropriately the method of random sequence generation (see Figure 2).

Twenty-three of the 56 included studies described appropriately the method of concealing allocation of participants to groups (see Figure 2).

Blinding

Twenty-five of the 56 included studies described the outcome assessors as being blinded to group allocation (see Figure 2).

Incomplete outcome data

Twenty-three of the 56 included studies described incomplete outcome data; however, the dropouts appeared not to be substantial. The dropouts were balanced between the groups and therefore do not appear to indicate potential bias.

Selective reporting

For the majority of studies, particularly the older trials, we could not find study protocols. In these cases we assessed whether all the outcomes listed in the methods section of the publication were then reported in the results section.

In most cases, where these study protocols were available, there was no evidence of selective reporting of outcomes relevant to this review.

Other potential sources of bias

We were not aware of other potential sources of bias.

Effects of interventions

See: **Summary of findings for the main comparison** Treadmill (with or without body weight support) versus other intervention for walking after stroke

Comparison 1: Treadmill (with or without body weight support) versus other intervention

Outcome 1.1: Walking speed (m/s) at the end of the treatment

Forty-seven studies, with a total of 2323 participants, provided data for walking velocity (metres per second, m/s) at study end (Analysis 1.1).

Overall, the use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled mean difference (MD, random-effects model) for walking velocity was 0.06 m/s (95% CI 0.03 to 0.09; P < 0.0001; level of heterogeneity I^2 = 44%; moderate-quality evidence) (Analysis 1.1).

In nine studies, with a total of 752 participants who were dependent in walking at study onset, the use of treadmill training in walking rehabilitation for people after stroke did not increase walking velocity significantly. The pooled mean difference (MD, random-effects model) for walking velocity was -0.01 m/s (95% CI -0.06 to 0.03; P = 0.52; level of heterogeneity I^2 = 0%; low-quality evidence) (Analysis 1.1).

In 38 studies, with a total of 1571 participants who were independent in walking at study onset, the use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.08 m/s (95% CI 0.05 to 0.12; P < 0.00001; level of heterogeneity I^2 = 49%; low-quality evidence) (Analysis 1.1).

We found statistically significant subgroup differences in walking velocity between dependent and independent walkers (Chi^2 = 11.94, df = 1, P = 0.0005).

Outcome 1.2: Walking endurance (m) at the end of treatment

Twenty-eight trials, with a total of 1680 participants, provided data for walking endurance (walking capacity; metres (m) walked in six minutes) at study end (Analysis 1.2).

Overall, the use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 14.19 m (95% CI 2.92 to 25.46; P = 0.09; level of heterogeneity I^2 = 27%; moderate-quality evidence) (Analysis 1.2).

In five studies, with a total of 639 participants who were dependent in walking at study onset, the use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was -5.09 m (95% CI -23.41 to 13.22; P = 0.59; level of heterogeneity I^2 = 0%; low-quality evidence) (Analysis 1.2).

In 23 studies, with a total of 1041 participants who were independent in walking at study onset, the use of treadmill training in walking rehabilitation for people after stroke increased walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 19.72 m (95% CI 6.61 to 32.83; P = 0.003; level of heterogeneity I^2 = 27%; low-quality evidence) (Analysis 1.2).

We found statistically significant subgroup differences in walking endurance between dependent and independent walkers (Chi^2 = 4.66, df = 1, P = 0.03).

Comparison 2: Treadmill and body weight support versus other interventions

Outcome 2.1: Dependence on personal assistance to walk at end of the treatment

Nineteen studies, with a total of 1210 participants, measured dependence on personal assistance to walk at the end of the treatment (Analysis 2.1).

Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the chance of walking independently compared with other physiotherapy interventions (RD 0.00, 95% CI -0.02 to 0.02; P = 0.92; level of heterogeneity I^2 = 0%) (Analysis 2.1).

In eight studies, with a total of 814 participants who were dependent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the chance of walking independently compared with other physiotherapy interventions (RD -0.00, 95% CI -0.03 to 0.03; P = 0.92; level of heterogeneity I^2 = 0%) (Analysis 2.1).

In 11 studies, with a total of 396 participants who were independent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the chance of walking independently compared with other physiotherapy interventions (RD -0.00, 95% CI -0.03 to 0.03; P = 1.00; level of heterogeneity I^2 = 0%) (Analysis 2.1).

We did not find statistically significant differences between dependent and independent walkers (Chi^2 = 0.01, df = 1, P = 0.94).

Outcome 2.2: Walking speed (m/s) at end of the treatment

Twenty-six studies, with a total of 1410 participants, provided data for walking velocity (metres per second, m/s) at study end (Analysis 2.2).

Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.07 m/s (95% CI 0.02 to 0.11; P = 0.005; level of heterogeneity I^2 = 52%) (Analysis 2.2).

In eight studies, with a total of 738 participants who were dependent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking velocity significantly. The pooled MD (random-effects model) for walking velocity was -0.01 m/s (95% CI -0.06 to 0.03; P = 0.51; level of heterogeneity I^2 = 0%) (Analysis 2.2).

In 18 studies, with a total of 672 participants who were independent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did increase walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.11 m/s (95% CI 0.06 to 0.17; P < 0.0001; level of heterogeneity I^2 = 42%) (Analysis 2.2).

We found statistically significant subgroup differences in walking velocity between dependent and independent walkers (Chi^2 = 14.88, df = 1, P = 0.0001).

Outcome 2.3: Walking endurance (m) at end of the treatment

Fifteen trials, with a total of 1062 participants, provided data for walking endurance (walking capacity; metres (m) walked in six minutes) at study end (Analysis 2.3).

Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 20.79 m (95% CI 0.43 to 41.14; P = 0.05; level of heterogeneity I^2 = 51%) (Analysis 2.3).

In five studies, with a total of 639 participants who were dependent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD

(random-effects model) for walking endurance was -5.09 m (95% CI -23.41 to 13.22; P = 0.59; level of heterogeneity I^2 = 0%) (Analysis 2.3).

In 10 studies, with a total of 423 participants who were independent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke increased walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 36.91 m (95% CI 11.14 to 62.68; P = 0.005; level of heterogeneity I^2 = 39%) (Analysis 2.3).

We found statistically significant subgroup differences in walking endurance between dependent and independent walkers (Chi^2 = 6.78, df = 1, P = 0.009).

Outcome 2.4: Dependence on personal assistance to walk at end of scheduled follow-up

Five studies, with a total of 285 participants, measured dependence on personal assistance to walk at the end of scheduled follow-up (Analysis 2.4).

In two studies, with a total of 170 participants who were dependent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the chance of walking independently compared with other physiotherapy interventions (RD -0.02, 95% CI -0.18 to 0.15; P = 0.83; level of heterogeneity I^2 = 40%) (Analysis 2.4).

In three studies, with a total of 115 participants who were independent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase the chance of walking independently compared with other physiotherapy interventions (RD 0.00, 95% CI -0.05 to 0.05; P = 1.00; level of heterogeneity I^2 = 0%) (Analysis 2.4).

Outcome 2.5: Walking speed (m/s) at end of scheduled follow-up

Twelve trials, with a total of 944 participants, provided data for walking velocity (metres per second, m/s) at the end of scheduled follow-up (Analysis 2.5).

Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking velocity at the end of scheduled follow-up significantly. The pooled MD (random-effects model) for walking velocity was 0.03 m/s (95% CI -0.05 to 0.10; P = 0.50; level of heterogeneity I^2 = 55%) (Analysis 2.5).

In three studies, with a total of 556 participants who were dependent in walking at the end of scheduled follow-up, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking velocity significantly. The pooled MD (random-effects model) for walking velocity was -0.05 m/s (95% CI -0.13 to 0.03; P = 0.20; level of heterogeneity I^2 = 0%) (Analysis 2.5).

In nine studies, with a total of 388 participants who were independent in walking at the end of scheduled follow-up, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.06 m/s (95% CI -0.03 to 0.15; P = 0.19; level of heterogeneity I^2 = 55%) (Analysis 2.5).

Outcome 2.6: Walking endurance (m) at end of scheduled follow-up

Ten trials, with a total of 882 participants, provided data for walking endurance (walking capacity; metres (m) walked in six minutes) at the end of scheduled follow-up (Analysis 2.6).

Overall, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking endurance at the end of scheduled follow-up significantly. The pooled MD (random-effects model) for walking endurance was 21.64 m (95% CI --4.70 to 47.98; P = 0.11; level of heterogeneity I^2 = 47%) (Analysis 2.6).

In two studies, with a total of 510 participants who were dependent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was -6.78 m (95% CI -34.57 to 21.02; P = 0.63; level of heterogeneity I^2 = 0%) (Analysis 2.6).

In eight studies, with a total of 372 participants who were independent in walking at study onset, the use of treadmill training with body weight support in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 31.55 m (95% CI 0.57 to 62.53; P = 0.05; level of heterogeneity I^2 = 41%) (Analysis 2.6).

Comparison 3: Treadmill training without body weight support versus other interventions

Outcome 3.1: Walking speed (m/s) at the end of the treatment

Twenty trials, with a total of 889 participants who were ambulatory at study onset, provided data for walking velocity (metres per second, m/s) at the end of the treatment (Analysis 3.1).

Overall, the use of treadmill training without body weight support in gait rehabilitation for ambulatory people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.05 m/s (95% CI 0.01 to 0.09; P = 0.01; level of heterogeneity I^2 = 26%) (Analysis 3.1).

Outcome 3.2: Walking endurance (m) at end of treatment

Thirteen trials, with a total of 608 participants, provided data for walking endurance (walking capacity; metres (m) walked in six minutes) at the end of the treatment (Analysis 3.2).

Overall, the use of treadmill training without body weight support in gait rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking velocity was 9.25 m (95% CI -1.99 to 20.50; P = 0.11; level of heterogeneity I^2 = 0%) (Analysis 3.2).

Comparison 4: Treadmill and body weight support versus treadmill only

In this update of the review, we found only one additional study for this outcome (Srivastava 2016). Only two trials with 99 participants

were included in this comparison (Srivastava 2016; Visintin 1998) (more details may be found in Analysis 4.1, Analysis 4.1; Analysis 4.2; Analysis 4.3; Analysis 4.4; Analysis 4.5; Analysis 4.6).

Because there are only sparse data for this comparison, we decided not to pool these studies and to describe the study results without presenting 'totals' and without applying inference tests (Analysis 4.1, Analysis 4.1; Analysis 4.2; Analysis 4.3; Analysis 4.4; Analysis 4.5; Analysis 4.6).

Comparison 5: Adverse events for all included trials

Outcome 5.1: Adverse events during the treatment

Twenty-four trials, with a total of 1504 participants, provided data for adverse events during the treatment (Analysis 5.1).

Overall, the use of treadmill training with or without body weight support in gait rehabilitation for people after stroke did not increase the risk of adverse events during the treatment (RD (random-effects model) 0.02, 95% CI -0.01 to 0.05; P = 0.14; level of heterogeneity I^2 = 51%). The adverse events during the treatment are described in detail for each trial in Table 3.

Comparison 6: Dropouts for all included trials

Outcome 6.1: Dropouts

6.1.1: Dropouts by the end of the treatment

Fifty-six trials, with a total of 3105 participants, provided data for dropouts at study end (Analysis 6.1).

Overall, the use of treadmill training with or without body weight support in gait rehabilitation for people after stroke did not increase the risk of participants dropping out by the end of the treatment (RD (random-effects model) 0.00, 95% CI -0.01 to 0.01; P = 0.74; level of heterogeneity I^2 = 0%). The reasons for dropouts and all adverse events during the treatment are described in detail for each trial in Table 3 and Table 4.

6.1.2: Dropouts by the end of scheduled follow-up (cumulative)

Fourteen trials, with a total of 780 participants, provided data for dropouts by the end of scheduled follow-up (cumulative) (Analysis 6.1).

Overall, the use of treadmill training with or without body weight support in gait rehabilitation for people after stroke did not increase the risk of participants dropping out by the end of scheduled follow-up (cumulative) (RD (random-effects model) -0.02, 95% CI -0.06 to 0.03; P = 0.47; level of heterogeneity I^2 = 0%). The reasons for dropouts are described in detail for each trial in Table 3 and Table 4.

Comparison 7: Sensitivity analysis: by trial methodology

Outcome 7.1: Walking speed (m/s) at the end of the treatment (all trials involving treadmill training)

To examine the robustness of the results, we specified variables (adequate sequence generation process, adequate concealed allocation and blinded assessors for primary outcome) in a sensitivity analysis that we believed could influence the size of the effect observed for walking speed (m/s) at the end of the treatment (Analysis 7.1). We included both participants who were dependent and independent in walking at study onset.

7.1.1: trials with adequate sequence generation process

We included 27 trials, with a total of 1242 participants, that had an adequate sequence generation process (Analysis 7.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.03 m/s (95% CI 0.00 to 0.06; P = 0.02; level of heterogeneity I^2 = 5%).

7.1.2: trials with adequate concealed allocation

We included 21 trials, with a total of 1266 participants, that had adequate concealed allocation (Analysis 7.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.06 m/s (95% CI 0.01 to 0.10; P = 0.008; level of heterogeneity I^2 = 26%).

7.1.3: trials with blinded assessors for the primary outcome

We included 24 trials, with a total of 1554 participants, that had blinded assessors for the primary outcome (Analysis 7.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.06 m/s (95% CI 0.02 to 0.11; P = 0.008; level of heterogeneity I^2 = 38%).

Comparison 8: Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of illness (independent in walking only)

Outcome 8.1: Walking speed (m/s) at the end of the treatment

In our planned subgroup analysis comparing walking speed at the end of the intervention phase in people in the acute and chronic phases of stroke, we arranged all included studies in one of two subgroups (acute and chronic phase).

8.1.1 Acute phase: less than or equal to three months after stroke, independent in walking

Eleven trials, with a total of 347 participants, investigated people in the acute or subacute phase, defined as less than or equal to three months after stroke (Analysis 8.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.15 m/s (95% CI 0.07 to 0.23; P = 0.0002; level of heterogeneity I^2 = 44%).

8.1.2 Chronic phase: more than three months after stroke, independent in walking

Twenty-six trials, with a total of 1209 participants, investigated people in the chronic phase, defined as more than three months after stroke (Analysis 8.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.06 m/s (95% CI 0.02 to 0.10; P = 0.001; level of heterogeneity I^2 = 39%).

We did not find statistically significant differences in walking velocity between participants treated in the acute/subacute phase compared with participants treated in the chronic phase after stroke (Chi^2 = 3.95, df = 1, P = 0.05).

Outcome 8.2: Walking endurance (m) at the end of the treatment

8.2.1 Acute phase: less than or equal to three months after stroke, independent in walking

Five trials, with a total of 178 participants, investigated people in the acute or subacute phase, defined as less than or equal to three months after stroke (Analysis 8.2). The use of treadmill training in walking rehabilitation for people after stroke increased walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 48.6 m (95% CI 23.97 to 73.32; P = 0.0001; level of heterogeneity I^2 = 6%).

8.2.2 Chronic phase: more than three months after stroke, independent in walking

Eighteen trials, with a total of 863 participants, investigated people in the chronic phase, defined as more than three months after stroke (Analysis 8.2). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 10.69 m (95% CI -0.28 to 21.66; P = 0.06; level of heterogeneity I^2 = 2%).

We found statistically significant differences in walking endurance between participants treated in the acute/subacute phase compared with participants treated in the chronic phase after stroke (Chi^2 = 7.59, df = 1, P = 0.006).

Comparison 9: Subgroup analysis: treadmill (with or without body weight support) versus other interventions, by intensity (frequency) of training (independent in walking only)

In our planned subgroup analysis comparing walking speed at the end of the intervention phase at different intensities (frequencies) of training, we arranged all included studies in one of three subgroups (treadmill training five times per week or more, three to four times per week, less than three times per week or unclear frequency).

Outcome 9.1: Walking speed (m/s) at the end of the treatment

9.1.1 Treadmill training five times per week or more

Nineteen trials, with a total of 671 participants, investigated people with an intensity (frequency) of training of five times per week or more (Analysis 9.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.04 m/s (95% CI 0.02 to 0.07; P = 0.0004; level of heterogeneity I^2 = 64%).

9.1.2 Treadmill training three to four times per week

Sixteen trials, with a total of 784 participants, investigated people with an intensity (frequency) of training three to four times per week (Analysis 9.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.08 m/s (95% CI 0.03 to 0.12; P = 0.0008; level of heterogeneity I^2 = 22%).

9.1.3 Treadmill training less than three times per week or unclear frequency

Three trials, with a total of 116 participants, investigated people with an intensity (frequency) of training less than three times a week (Analysis 9.1). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.02 m/s (95% CI -0.06 to 0.10; P = 0.61; level of heterogeneity I^2 = 0%).

We did not find statistically significant differences in walking velocity between participants treated at different intensities of training (Chi^2 = 2.09, df = 2, P = 0.35).

Outcome 9.2: walking endurance (m) at the end of the treatment

9.2.1 Treadmill training five times per week

Nine trials, with a total of 392 participants, investigated people with an intensity (frequency) of training of five times a week or more (Analysis 9.2). The use of treadmill training in walking rehabilitation for people after stroke increased walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 27.25 m (95% CI 5.37 to 49.13; P = 0.01; level of heterogeneity I^2 = 45%).

9.2.2 Treadmill training three to four times per week

Thirteen trials, with a total of 621 participants, investigated people with an intensity (frequency) of training of three to four times per week (Analysis 9.2). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 12.41 m (95% CI -3.15 to 27.97; P = 0.12; level of heterogeneity I^2 = 10%).

9.2.3 Treadmill training less than three times per week or unclear

One trial, with a total of 28 participants, investigated people with an intensity (frequency) of training of less than three times a week (Analysis 9.2). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was -15.00 m (95% CI -133.26 to 103.26; P = 0.80; level of heterogeneity not applicable).

We did not find statistically significant differences in walking endurance between participants treated at different intensities of training (Chi^2 = 1.46, df = 2, P = 0.48).

Comparison 10: Subgroup analysis: treadmill (with or without body weight support) versus other interventions, by duration of training period (independent in walking only)

In our planned subgroup analysis comparing walking speed at the end of the intervention phase after different durations of treatment, we arranged all included studies into one of three subgroups (treadmill training duration of more than four weeks, equal to four weeks or less than four weeks).

Outcome 10.1 Walking speed (m/s) at the end of the treatment

10.1.1 Treadmill training duration of more than four weeks

Fourteen trials, with a total of 802 participants, investigated people with a duration of training of more than four weeks (Analysis 10.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.05 m/s (95% CI 0.01 to 0.09; P = 0.02; level of heterogeneity I^2 = 0%).

10.1.2 Treadmill training duration of four weeks

Thirteen trials, with a total of 404 participants, investigated people with a duration of training of four weeks (Analysis 10.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.13 m/s (95% CI 0.07 to 0.19; P < 0.0001; level of heterogeneity I^2 = 30%).

10.1.3 Treadmill training duration of less than four weeks

Eleven trials, with a total of 365 participants, investigated people with a duration of training of less than four weeks (Analysis 10.1). The use of treadmill training in walking rehabilitation for people after stroke increased walking velocity significantly. The pooled MD (random-effects model) for walking velocity was 0.08 m/s (95% CI 0.01 to 0.14; P = 0.03; level of heterogeneity I^2 = 63%).

We found statistically significant differences in walking velocity between participants treated with training for different durations (Chi^2 = 8.68, df = 2, P = 0.01).

Outcome 10.2: Walking endurance (m) at the end of the treatment

In our planned subgroup analysis comparing walking endurance at the end of the intervention phase after different durations of treatment, we arranged all included studies into one of three subgroups (treadmill training duration of more than four weeks, equal to four weeks, or less than four weeks).

10.2.1 Treadmill training duration of more than four weeks

Twelve trials, with a total of 706 participants, investigated people with a duration of training of more than four weeks (Analysis 10.2). The use of treadmill training in walking rehabilitation for people after stroke increased walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 19.09 m (95% CI 2.29 to 35.88; P = 0.03; level of heterogeneity I^2 = 0%).

10.2.2 Treadmill training duration of four weeks

Five trials, with a total of 146 participants, investigated people with a duration of training of four weeks (Analysis 10.2). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 29.40 m (95% CI -4.75 to 63.54; P = 0.09; level of heterogeneity I^2 = 65%).

10.2.3 Treadmill training duration of less than four weeks

Four trials, with a total of 129 participants, investigated people with a duration of training of less than four weeks (Analysis 10.2). The use of treadmill training in walking rehabilitation for people after stroke did not increase walking endurance significantly. The pooled MD (random-effects model) for walking endurance was 9.82 m (95% CI -15.48 to 35.13; P = 0.45; level of heterogeneity I^2 = 13%).

We did not find statistically significant differences in walking endurance between participants treated with training for different durations (Chi^2 = 0.85, df = 2, P = 0.66).

Other outcomes

We did not analyse the secondary outcomes of participant quality of life, ability to perform activities of daily living, and the combined outcomes of death or dependency, and death or institutional care either because these variables were not reported or due to insufficient data in many of the included studies.

We did not perform the planned subgroup analyses for the types of co-interventions implemented in conjunction with treadmill training due to insufficient data.

DISCUSSION

Summary of main results

The aim of this review was to evaluate the effect of treadmill training and body weight support, individually or in combination, for walking after stroke. We included 56 trials with 3105 participants in this update. Overall, the use of treadmill training with body weight support did not increase the chance of walking independently compared with people after stroke receiving other physiotherapy interventions, but not treadmill training. The use of treadmill training with body weight support in walking rehabilitation for people after stroke did increase the walking velocity and walking endurance significantly compared with other physiotherapy interventions.

Overall, treadmill training with or without body weight support produced statistically significant higher walking speed and endurance, 0.06 m/s and 14 m respectively, compared with people not receiving treadmill training. For people who could walk independently at the start of treatment, treadmill training with or without body weight support produced statistically significant higher walking speed and endurance, 0.09 m/s and 20 m respectively, compared with people not receiving treadmill training. These results raise the question: how clinically relevant are these statistically significant effects?

For people after stroke, Flansbjer 2005 described the smallest possible change (the standard error of measurement (SEM) and the smallest real clinical differences (95% SRD). The SEMs and the 95% SRDs for walking speed were 0.07 m/s and 0.15 to 0.25 m/s and the SEMs and the 95% SRDs for walking endurance were 18.6 m and 37 to 66 m. Our results might, according to Flansbjer 2005, be interpreted as follows: the overall effects of treadmill training, with or without body weight support, can not be measured in practice and should not be interpreted as a clinically relevant improvement.

We did not find any benefit for people after stroke who could not walk independently at the start of treatment. We did not find enough studies of the effects of treadmill training, with or body weight support, on activities and quality of life to draw any appropriate conclusions, nor did we find enough studies of the effects of body weight support without treadmill training to draw any appropriate conclusions.

Adverse events and dropouts did not occur more frequently in people receiving treadmill training and these were not judged to be clinically serious events.

Our subgroup analysis showed that, for people after stroke who walked independently, treadmill training in the first three months after stroke produced walking speeds that were statistically but not clinically relevant (Flansbjer 2005). For people treated in the chronic phase, the effects on walking speed were lower (and not clinically relevant). However, the subgroup differences did not differ significantly.

Our subgroup analysis showed that, for people after stroke who walked independently, treadmill training in the first three months after stroke produced a walking endurance that was statistically and clinically relevant (Flansbjer 2005). For people treated in the chronic phase, the effects on walking endurance were lower (not clinically relevant). The subgroup differences did differ significantly, indicating that people treated in the first three months after stroke had higher gains in walking endurance compared with training in the chronic phase after stroke.

Our subgroup analysis showed that, for people after stroke who walked independently, treadmill training with higher intensities (frequency of training: five times versus three to four times versus less than three times per week) may produce greater effects on walking speed and endurance. However, this trend toward subgroup differences was not significant.

Possible conclusions based on our findings are that treadmill training can be used when people after stroke can walk independently and when improvement of walking speed and endurance is the aim of therapy. The greatest effect of treadmill training is to be expected in the first three months after stroke. It was, however, not absolutely clear from this review if therapists should apply particular periods or particular frequencies of treatments, for example, training for five times a week or for four weeks.

Overall completeness and applicability of evidence

The results of this review seem to be quite generalisable to inpatient settings in industrialised countries. However, there are factors producing uncertainty for generalisations.

- The investigated study population was quite heterogeneous (e.g. age, time post-stroke, severity of stroke and especially walking ability).
- The investigated experimental and control conditions were heterogeneous (e.g. type of training, frequency, and duration of training; some studies had no active control group or were compared with no intervention).

Hence, the results may be of limited applicability for all people after stroke.

Quality of the evidence

We found heterogeneity regarding trial design (parallel-group or cross-over design, two or more intervention groups), but it is not clear if this could have limited the quality of the evidence. Furthermore, in our sensitivity analysis examining the effects of methodological quality on the effectiveness of the intervention, we found that the benefits (improving walking speed) were relatively robust when we removed trials with an inadequate sequence generation process, inadequate concealed allocation, and no blinded assessors for the primary outcome (Analysis 7.1).

Although the methodological quality of the included trials generally seemed moderate (Figure 2), trials investigating treadmill training with or without body weight support are subject to potential methodological limitations. These limitations included inability to blind the therapist and participants, so-called contamination (provision of the intervention to the control group), and co-intervention (when the same therapist unintentionally provided additional care to either treatment or comparison group). All these potential methodological limitations introduced the possibility of performance bias. However, as discussed previously, this was not supported in our sensitivity analyses by methodological quality.

Potential biases in the review process

The methodological rigour of Cochrane reviews minimises bias in the process of conducting systematic reviews. We are confident that our detailed search strategy, combined with detailed handsearching efforts, identified all relevant trials. It is possible that we did not identify studies published in the grey literature, but it would be unlikely that this would have a significant impact on our results. Because the grey literature tends to include trials with relatively small numbers of participants and inconclusive results, inclusion of this literature may have actually decreased the size of the effect detected in our review (McAuley 2000).

Another potential source for the introduction of bias could have been that one of the review authors (JM) was involved in conducting and analysing one of the included trials (Pohl 2002). However, the third review author (BE) extracted the outcome data from raw data and described the risk of bias of this trial. Excluding Pohl 2002 from the pooled analyses did not change the results significantly, so we believe that this one trial has not biased our overall evidence.

Agreements and disagreements with other studies or reviews

There are several recent reviews about treadmill training, with or without body weight support; for example, two reviews were published in 2013 (Charalambous 2013; Polese 2013).

The review of Polese 2013 included nine studies of treadmill training with 977 participants and concluded that treadmill training resulted in faster walking than no intervention or a non-walking intervention immediately after the intervention period (MD 0.14 m/s, 95% CI 0.09 to 0.19). The review of Charalambous 2013 included 15 studies of treadmill training and concluded that treadmill-based interventions post-stroke may increase and retain walking speed, but a pooled analysis with forest plots was not provided. In comparison, we found more studies (44 studies included in this update) than in the reviews of Charalambous 2013 and Polese 2013 and we found smaller effects on walking speed, MD 0.07 m/s, 95% CI 0.03 to 0.11 (based on 35 included studies of treadmill training with 1891 participants). These differences could be due to the comprehensive search in our review update and to our inclusion of studies not published in English. This update is the most comprehensive review about the topic to date.

In this update of the review, we have found significant effects for walking velocity and endurance but not for dependence, and we also found that people who have had a stroke and who can walk independently profit more from treadmill training than those who cannot walk. Initially, this might be difficult to interpret. However, we believe that the overall results of this review were somewhat 'confounded' by the results of people who could not walk. We found evidence that this participant group may not profit from treadmill training. Treadmill training appears, therefore, to be an appropriate adjunct intervention that might improve certain important walking parameters, such as speed and endurance for people who are already able walk alone. This might appear a

little ironic to researchers because treadmill training with body weight support was designed to get non-ambulatory walkers walking. Another Cochrane review found evidence that the chance of regaining independent walking ability after stroke increases when electromechanical and robotic-assisted gait-training devices are used in combination with physiotherapy (Mehrholz 2017). Interestingly, whereas independent walking improved, neither walking velocity nor walking capacity improved. Perhaps one conclusion could be that different interventions are suitable for different participants. For example, for severely affected people who cannot walk independently, electromechanical and robotic-assisted gait-training devices in combination with physiotherapy are recommended (Mehrholz 2017). However, when people who have had a stroke recover and start walking, then treadmill training may improve important walking parameters such as speed and endurance, as our update showed. Therefore, the combination of approaches should be considered.

Finally, it should be mentioned that treadmill training in and of itself is perhaps not the 'main issue'. We believe that treadmill training just offers a very easy approach for high-intensity, repetitive, task-specific walking training, which is recommended for gait rehabilitation (Langhorne 2009).

AUTHORS' CONCLUSIONS

Implications for practice

The results of this review were conclusive in part. Overall, after stroke, people who receive treadmill training, with or without body weight support, are not more likely to improve their ability to walk independently, but their speed of walking and their walking capacity may improve. More specifically, those who are able to walk independently (but not those who are unable to walk independently) seem to benefit from this type of intervention. This review found that improvements in walking speed and endurance in people who are able to walk independently have no persisting beneficial effects. However, our review suggests that, after stroke, people who are not able to walk independently at the start of treatment may not benefit from treadmill training with or without body weight support.

In practice, therapists should be aware that treadmill training may be used as an option but not as stand-alone treatment to improve the walking speed and endurance of people who are able to walk independently. It appears that people who are able to walk independently, but not those who are unable to walk independently, may profit from treadmill training, with and without body weight support, to improve their walking abilities.

Implications for research

Further research should specifically investigate the effects of different frequencies, durations, or intensities (in terms of speed increments and inclination) of treadmill training, as well as the use of handrails. To answer these research questions, future trials should include people who are already ambulatory and exclude those who are non-ambulatory.

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REFERENCES

References to studies included in this review

Ada 2003 *{published and unpublished data}*

Ada L, Dean C, Crompton S, Hall J, Bampton J. The efficacy of treadmill training in improving walking in individuals after stroke in the community: a placebo-controlled, randomised trial. VIIth International Physiotherapy Congress. Sydney: Australian Physiotherapy Association, 2002:61.

Ada L, Dean C, Hall J, Bampton J, Crompton S. A treadmill and overground walking program improves walking in individuals residing in the community after stroke: a placebo-controlled, randomised trial. 14th International Congress of The World Confederation for Physical Therapy. Spain, Barcelona. 2003:RR-PL-1170.

Ada L, Dean CM, Hall JM, Bampton J, Crompton S. A treadmill and overground walking program improves walking in individuals residing in the community after stroke: a placebo-controlled randomised trial. *Internal Medicine Journal* 2004;**34**(1-2):A7.

* Ada L, Dean CM, Hall JM, Bampton J, Crompton S. A treadmill and overground walking program improves walking in persons residing in the community after stroke: a placebo-controlled, randomized trial. Archives of Physical Medicine and Rehabilitation 2003; Vol. 84, issue 10:1486-91.

NCT00167531. The efficacy of treadmill training in establishing walking after stroke. clinicaltrials.gov (first received 12 September 2005).

Ada 2010 *{published data only}*

Ada L, Dean C, Morris M. Establishing walking using treadmill training in non-ambulatory patients during inpatient stroke rehabilitation: the MOBILISE trial. *Australian Journal of Physiotherapy* 2009;**4 Suppl**:2.

Ada L, Dean C, Morris M, Simpson J, Katrak P. Establishing walking using treadmill walking with body weight support in subacute non-ambulatory stroke: the MOBILISE Trial I. *International Journal of Stroke* 2010;**5**:24-5.

Ada L, Dean CM, Morris ME. Supported treadmill training to establish walking in non-ambulatory patients early after stroke. *BMC Neurology* 2007;**7**:29.

* Ada L, Dean CM, Morris ME, Simpson JM, Katrak P. Randomized trial of treadmill walking with body weight support to establish walking in subacute stroke: the MOBILISE trial. *Stroke* 2010;**41**(6):1237-42.

Dean C, Ada L, Bampton J, Morris M, Katrak P, Potts S. Improving walking speed and capacity using treadmill walking with body weight support in subacute non-ambulatory stroke: the Mobilise trial II. *International Journal of Stroke* 2010;**5**:12-3.

Dean C, Ada L, Morris M. Improving walking using treadmill training in non-ambulatory patients during inpatient stroke rehabilitation: the MOBILISE trial. *Australian Journal of Physiotherapy* 2009;**4 Suppl**:8.

Dean CM, Ada L, Bampton J, Morris ME, Katrak PH, Potts S. Treadmill walking with body weight support in subacute non-ambulatory stroke improves walking capacity more than overground walking: a randomised trial. *Journal of Physiotherapy* 2010;**56**(2):97-103.

Ada 2013 *{published data only}*

ACTRN12607000227493. AMBULATE: 2 months versus 4 months of walking training to improve community ambulation after stroke. www.anzctr.org.au (first received 24 April 2007).

* Ada L, Dean C, Lindley R. Randomized trial of treadmill training to improve walking in community-dwelling people after stroke: the AMBULATE trial. *International Journal of Stroke* 2013;**8**(6):436-44.

Ada L, Dean CM, Lindley R, Lloyd G. Improving community ambulation after stroke: the AMBULATE trial. *BMC Neurology* 2009;**9**:8.

Ada L, Dean CM, Lindley R, Vargas J. Improving walking after stroke: the Ambulate trial. *Neurorehabilitation and Neural Repair* 2012;**26**(6):674-5.

Lindley RI, Dean C, Ada L. Can treadmill training improve walking in the chronic phase of stroke? The AMBULATE randomised controlled trial. Cerebrovascular Diseases 2012; Vol. 33, issue Suppl 2:61.

Bonnyaud 2013 *{published data only}*

Bonnyaud C, Pradon D, Zory R, Bensmail D, Vuillerme N, Roche N. Does a single gait training session performed either overground or on a treadmill induce specific short-term effects on gait parameters in patients with hemiparesis? A randomized controlled study. *Topics in Stroke Rehabilitation* 2013;**20**:509-18.

Bonnyaud 2013a *{published data only}*

* Bonnyaud C, Pradon D, Zory R, Bussel B, Bensmail D, Vuillerme N, et al. Effects of a gait training session combined with a mass on the non-paretic lower limb on locomotion of hemiparetic patients: a randomized controlled clinical trial. *Gait & Posture* 2013;**37**:627-30.

Bonnyaud C, Zory R, Robertson J, Bensmail D, Vuillerme N, Roche N. Effect of an overground training session versus a treadmill training session on timed up and go in hemiparetic patients. *Topics in Stroke Rehabilitation* 2014;**21**:477-83.

Combs-Miller 2014 *{published data only}*

Combs SA, Tucker L, Harmeyer A, Ertel T, Colburn D, Parameswaran AK. Body weight-supported treadmill training vs. over-ground walking training for persons with chronic stroke: a randomized controlled trial. *Archives of Physical Medicine & Rehabilitation* 2012;**93**(10):e36.

* Combs-Miller SA, Kalpathi PA, Colburn D, Ertel T, Harmeyer A, Tucker L, et al. Body weight-supported treadmill training vs. overground walking training for persons with chronic stroke: a pilot randomized controlled trial. *Clinical Rehabilitation* 2014;**28**:873-84.

NCT01180738. Body weight supported treadmill training vs. overground walking training in persons with chronic stroke. clinicaltrials.gov/show/NCT01180738 (first received 9 August 2010).

Da Cunha Filho 2002 *{published and unpublished data}*

Da Cunha Filho IT. Acute Stroke Rehabilitation Outcomes with Supported Treadmill Ambulation Training [PhD thesis]. Texas Woman's University, 2001.

* Da Cunha Filho IT, Lim PA, Qureshy H, Henson H, Monga T, Protas EJ. Gait outcomes after acute stroke rehabilitation with supported treadmill ambulation training: a randomized controlled pilot study. *Archives of Physical Medicine and Rehabilitation* 2002;**83**(9):1258-65.

Da Cunha Filho IT, Lim PAC, Qureshy H, Henson H, Monga T, Protas EJ. A comparison of regular rehabilitation and regular rehabilitation with supported treadmill ambulation training for acute stroke patients. *Journal of Rehabilitation Research and Development* 2001;**38**(2):245-55.

Lim PAC, Henson H, Cunha I, Qureshy H, Monga TN, Protas EJ. Body weight-supported gait training in stroke patients. *American Journal of Physical Medicine* 2000;**79**(2):203.

NCT00037895. Stroke rehabilitation outcomes with supported treadmill ambulation training. clinicaltrials.gov (first received 24 May 2002).

Deniz 2011 *{published data only}*

Deniz L, Armagan O, Ozgen M, Oner S. Effectiveness of gait training with partial body-weight support in subacute stroke patients. *Turk Serebrovaskuler Hastaliklar Dergisi* 2011;**17**(1):13-9.

DePaul 2015 *{published data only}*

DePaul VG, Wishart LR, Richardson J, Thabane L, Ma J, Lee TD. Varied overground walking training versus body-weight-supported treadmill training in adults within 1 year of stroke: a randomized controlled trial. *Neurorehabilitation and Neural Repair* 2015;**29**:329-40.

Du 2006 *{published data only}*

Du JB, Song WQ, Wang MB. The application of partial body weight support treadmill training in hemiplegia rehabilitation after stroke. *Chinese Journal of Cerebrovascular Diseases* 2006;**3**(8):361-4.

Duncan 2011 *{published data only}*

Duncan P, Sullivan K, Behrman A, Azen S, Wu S, Dobkin B, et al. Locomotor Experience Applied Post-Stroke (LEAPS): a randomized controlled trial. *International Journal of Stroke* 2008;**3**(Suppl 1):132.

Duncan PW. Locomotor Experience Applied Post-Stroke (LEAPS). *Stroke* 2007;**38**(10):e120.

* Duncan PW, Sullivan KJ, Behrman AL, Azen SP, Wu SS, Nadeau SE, et al. Body-weight-supported treadmill rehabilitation after stroke. *New England Journal of Medicine* 2011;**364**(21):2026-36.

Duncan PW, Sullivan KJ, Behrman AL, Azen SP, Wu SS, Nadeau SE, et al. Locomotor Experience Applied Post-Stroke (LEAPS): a randomized controlled trial (abstract - CT P20). International Stroke Conference; 2008 February 20-22. New Orleans (USA): American Stroke Association, 2008.

Duncan PW, Sullivan KJ, Behrman AL, Azen SP, Wu SS, Nadeau SE, et al. Protocol for the Locomotor Experience Applied Post-stroke (LEAPS) trial: a randomized controlled trial. *BMC Neurology* 2007;**7**:39.

NCT00243919. Locomotor Experience Applied Post Stroke trial (LEAPS). clinicaltrials.gov (first received 24 October 2005).

Nadeau SE, Wu SS, Dobkin BH, Azen SP, Rose DK, Tilson JK, et al. Effects of task-specific and impairment-based training compared with usual care on functional walking ability after inpatient stroke rehabilitation: Leaps trial. *Neurorehabilitation and Neural Repair* 2013;**27**(4):370-80.

Rose DK, Behrman AL, Cen Y, Sullivan KJ, Martin D, Schofield RS, et al. Response to exercise tolerance testing in subacute stroke across severity levels. *Stroke* 2008;**39**(2):618-9.

Tilson JK, Sullivan KJ, Cen SY, Rose DK, Koradia CH, Azen SP, et al. Meaningful gait speed improvement during the first 60 days poststroke: minimal clinically important difference. *Physical Therapy* 2010;**90**(2):196-208.

Eich 2004 *{published data only}*

Eich HJ, Hesse S, Mach H. Aerobic endurance training of hemiparetic patients who are able to walk, results of a prospective randomised study [Aerobes ausdauertraining gehfähiger hemiparetischer patienten, ergebnisse einer prospektiven randomisierten studie]. *Deutsche Zeitschrift fur Sportmedizin* 2003;**54**(7-8):S98.

* Eich HJ, Mach H, Werner C, Hesse S. Aerobic treadmill plus Bobath walking training improves walking in subacute stroke: a randomised controlled trial. *Clinical Rehabilitation* 2004;**18**:640-51.

Eich HJ, Parchmann H, Hesse S, Mach H, Werner C. Aerobic treadmill training plus physiotherapy improves walking ability in subacute stroke patients. A randomized controlled study. *Neurologie und Rehabilitation* 2004;**10**(4):187-216.

Hesse S, Eich HJ, Mach H, Parchmann H, Werner C. Aerobic treadmill training plus physiotherapy improves walking speed and capacity in subacute, moderately affected patients after stroke [Aerobes laufbandtraining plus physiotherapie verbessert das gehen von mäßig schwer betroffenen patienten nach schlaganfall]. *Neurologie und Rehabilitation* 2005;**11**(1):7-12.

Hesse S, Eich HJ, Mach H, Werner C. Aerobic treadmill training of ambulatory hemiparetic patients: a randomised study. 3rd World Congress in Neurological Rehabilitation; 2002; Venice (Italy). World Federation for NeuroRehabilitation, 2002.

Hesse S, Eich HJ, Mach H, Werner C. Aerobic treadmill training of ambulatory hemiparetic patients: a randomized study. *Neurorehabilitation & Neural Repair* 2001;**15**(4):311.

Mach H, Werner C, Eich HJ, Hesse S. Aerobic treadmill training in hemiparetic patients: a randomized study. *Neurologie und Rehabilitation* 2003;**9**(6):S6.

Franceschini 2009 *{published data only}*

* Franceschini M, Carda S, Agosti M, Antenucci R, Malgrati D, Cisari C. Walking after stroke: what does treadmill training with body weight support add to overground gait training in patients early after stroke? A single-blind, randomized, controlled trial. *Stroke* 2009;**40**(9):3079-85.

Saccavini M, Zaccaria B, Franceschini M, Maestrini E, Agosti M, Mammi P, et al. Treadmill walking with bodyweight support in stroke patients during acute phase: a randomized controlled trial. *Cerebrovascular Diseases* 2009;**27**(Suppl 6):216-7.

Gama 2017 *{published data only}*

Gama GL, Celestino ML, Barela JA, Forrester L, Whittal J, Barela AM. Effects of gait training with body weight support on a treadmill versus overground in individuals with stroke. *Archives of Physical Medicine and Rehabilitation* 2017;**98**(4):738-45.

Gan 2012 *{published data only}*

Gan SW, Azarcon AC, Cadiao JJ, Gabua AM, Javier RS, Orayle EM, et al. A randomized controlled trial on the efficacy of body weight support overground ambulation versus body weight support treadmill training among post-stroke patients of a tertiary hospital. *Physical Medicine and Rehabilitation* 2012;**1**:S182.

Globas 2011 *{published data only}*

* Globas C, Becker C, Cerny J, Lam JM, Lindemann U, Forrester LW, et al. Chronic stroke survivors benefit from high-intensity aerobic treadmill exercise: a randomized controlled trial. *Neurorehabilitation and Neural Repair* 2011;**26**(1):85-95.

Globas C, Becker C, Cerny J, Lam JM, Lindemann U, Forrester LW, et al. Elderly chronic stroke survivors benefit from aerobic treadmill exercise: a randomized, controlled trial. *Stroke* 2011;**42**(3):e323.

Lam JM, Globas C, Cerny J, Hertler B, Uludag K, Forrester LW, et al. Predictors of response to treadmill exercise in stroke survivors. *Neurorehabilitation and Neural Repair* 2010;**24**(6):567-74.

NCT00614224. Structural neuroplasticity associated with aerobic treadmill training in geriatric chronic stroke survivors. clinicaltrials.gov. (first received 31 January 2008).

Hoyer 2012 *{published data only}*

Hoyer E, Jahnsen R, Stanghelle JK, Strand LI. Body weight supported treadmill training versus traditional training in patients dependent on walking assistance after stroke: a randomized controlled trial. *Disability Rehabilitation* 2012;**34**(3):210-9.

Jaffe 2004 *{published and unpublished data}*

Brown DA, Jaffe DL, Buckley EL. Use of virtual objects to improve gait velocity in individuals with post-stroke hemiplegia. *Neurology Report* 2002;**26**:105.

Jaffe DL. Results using stepping-over response training to improve walking in individuals with poststroke hemiplegia. 3rd National Rehabilitation Research and Development Conference. Arlington (USA), 2002.

Jaffe DL. Using virtual reality to improve walking following stroke. Center on Disabilities Technology and Persons with Disabilities Conference. Northridge, California (USA), 2002.

Jaffe DL, Brown DA. Improving stepping-over responses in the elderly using simulated obstacles. www.stanford.edu/~dljaffe/SOR/jaffe.pdf (accessed prior to 14 July 2017).

* Jaffe DL, Brown DA, Pierson-Carey CD, Buckley EL, Lew HL. Stepping over obstacles to improve walking in individuals with poststroke hemiplegia. *Journal of Rehabilitation Research and Development* 2004;**41**(3A):283-92.

Kang 2012 *{published data only}*

Kang H-K, Kim Y, Chung Y, Hwang S. Effects of treadmill training with optic flow on balance and gait in individuals following stroke: randomized controlled trials. *Clinical Rehabilitation* 2012;**26**(3):246-55.

Kim 2011 *{published data only}*

Kim C, Gong W, Kim S. The effects of lower extremity muscle strengthening exercise and treadmill walking exercise on the gait and balance of stroke patients. *Journal of Physical Therapy Science* 2011;**23**(3):405-8.

Kim 2016 *{published data only}*

Kim N, Lee BH, Kim Y, Min W. Effects of virtual reality treadmill training on community balance confidence and gait in people post-stroke: a randomized controlled trial. *Journal of Experimental Stroke and Translational Medicine* 2016;**9**:1-7.

Kosak 2000 *{published and unpublished data}*

Kosak M, Reding M. Early aggressive mobilization is as effective as treadmill training for ambulation recovery in patients with stroke. *Journal of Stroke and Cerebrovascular Diseases* 1998;**7**(5):372.

Kosak MC, Brennan JA, Slomovicz LG, Tachkov A, Reding MJ. Body weight supported treadmill training versus traditional physical therapy. *Stroke* 1997;**28**(1):268.

* Kosak MC, Reding MJ. Comparison of partial body weight-supported treadmill gait training versus aggressive bracing assisted walking post stroke. *Neurorehabilitation and Neural Repair* 2000;**14**(1):13-9.

Kuys 2011 *{published data only}*

ACTRN12607000412437. Treadmill walking to improve walking and fitness following stroke: a single blinded pilot randomised controlled trial. www.anzctr.org.au (first received 16 May 2007).

Kuys S, Brauer S, Ada L. Treadmill training to improve walking following stroke: a randomised controlled trial. *International Journal of Stroke* 2008;**3**(Suppl):347.

Kuys SS, Brauer SG, Ada L. High-intensity treadmill walking during inpatient rehabilitation: feasibility of a randomised trial. Australian Journal of Physiotherapy 2009, issue 4 Suppl:12-3.

* Kuys SS, Brauer SG, Ada L. Higher-intensity treadmill walking during rehabilitation after stroke in feasible and not detrimental to walking pattern or quality: a pilot randomized trial. *Clinical Rehabilitation* 2011;**25**(4):316-26.

Langhammer 2010 *{published data only}*

Langhammer B, Johan, Stanghelle K. Outdoors or indoors walking, what is more beneficial? A comparison of exercise methods in a randomized trial. *Brain Injury* 2010;**24**(3):172.

Langhammer B, Stanghelle JK. Exercise on a treadmill or walking outdoors? A randomized controlled trial comparing effectiveness of two walking exercise programmes late after stroke. *Clinical Rehabilitation* 2010;**24**(1):46-54.

Langhammer B, Stanghelle JK. Improving gait after stroke-treadmill or walking; quantity or quality. *Journal of Cyber Therapy and Rehabilitation* 2009;**2**(3):191-8.

Laufer 2001 *{published data only}*

Laufer Y, Dickstein R, Chefez Y, Marcovitz E. The effect of treadmill training on the ambulation of stroke survivors in the early stages of rehabilitation: a randomized study. *Journal of Rehabilitation Research and Development* 2001;**38**(1):69-78.

Liston 2000 *{published and unpublished data}*

* Liston R, Mickelborough J, Harris B, Hann AW, Tallis RC. Conventional physiotherapy and treadmill re-training for higher-level gait disorders in cerebrovascular disease. *Age & Ageing* 2000;**29**(4):311-8.

Mickelborough J, Liston R, Harris B, Wynn Hann A, Tallis RC. An evaluation of conventional physiotherapy and treadmill re-training of higher-level gait disorders in patients with cerebral multi-infarct states. *Age & Ageing* 1999;**28 Suppl 2**:54.

Luft 2008 *{published data only}*

Lam JM, Globas C, Cerny J, Hertler B, Uludag K, Forrester LW, et al. Predictors of response to treadmill exercise in stroke survivors. *Neurorehabilitation and Neural Repair* 2010;**24**(6):567-74.

* Luft AR, Macko RF, Forrester LW, Villagra F, Ivey F, Sorkin JD, et al. Treadmill exercise activates subcortical neural networks and improves walking after stroke: a randomized controlled trial. *Stroke* 2008;**39**(12):3341-50.

MacKay-Lyons 2013 *{published data only}*

MacKay-Lyons M, McDonald A, Matheson J, Howlett J. Physiological changes following a 12-week program of body-weight supported treadmill training early post-stroke: a randomized clinical trial. *International Journal of Stroke* 2008;**3**(Suppl):348.

* Mackay-Lyons M, McDonald A, Matheson J, Eskes G, Klus MA. Dual effects of body-weight supported treadmill training on cardiovascular fitness and walking ability early after stroke: a randomized controlled trial. *Neurorehabilitation and Neural Repair* 2013;**27**(7):644-53.

Macko 2005 *{published and unpublished data}*

Clark B, Harris-Love M, Forrester L, Macko R, Smith GV. Effects of treadmill training on dynamic balance measures in chronic hemiparesis. 3rd World Congress in Neurological Rehabilitation; Venice (Italy). World Federation for NeuroRehabilitation, 2002.

Clark B, Harris-Love M, Forrester L, Macko R, Smith GW. Effects of treadmill training on dynamic balance measures in chronic hemiparesis. *Neurorehabilitation and Neural Repair* 2001;**15**(4):315.

Ivey FM, Ryan AS, Hafer-Macko CE, Goldberg AP, Macko RF. Treadmill aerobic training improves glucose tolerance and indices of insulin sensitivity in disabled stroke survivors: a preliminary report. *Stroke* 2007;**38**(10):2752-8.

Limpar P, Macko RF, Sorkin JD, Katzel LI, Hanley DF. Safety of treadmill aerobic exercise in chronic hemiparetic stroke patients. *Stroke* 2004;**35**(1):286.

* Macko RF, Ivey FM, Forrester LW, Hanley D, Sorkin JD, Katzel LI, et al. Treadmill exercise rehabilitation improves ambulatory function and cardiovascular fitness in patients with chronic stroke: a randomized, controlled trial. *Stroke* 2005;**36**(10):2206-11.

NCT00018421. Effects of exercise on patients with hemiparetic stroke. clinicaltrials.gov/show/NCT00018421 (first received 3 July 2001).

Mao 2015 *{published data only}*

Mao YR, Lo WL, Lin Q, Li L, Xiao X, Raghavan P, et al. The effect of body weight support treadmill training on gait recovery, proximal lower limb motor pattern, and balance in patients with subacute stroke. *BioMed Research International* 2015;**2015**:175719.

Mehrberg 2001 *{published data only}*

Mehrberg RD, Flick C, Dervay J, Carmody J, Carrington C, Jermer M. Clinical evaluation of a new over ground partial body weight support assistive device in hemiparetic stroke patients. *Archives of Physical Medicine & Rehabilitation* 2001;**82**:1293.

Middleton 2014 *{published data only}*

Middleton A, Merlo-Rains A, Peters DM, Greene JV, Blanck EL, Moran R, et al. Body weight-supported treadmill training is no better than overground training for individuals with chronic stroke: a randomized controlled trial. *Topics in Stroke Rehabilitation* 2014;**21**:462-76.

Moore 2010 *{published data only}*

* Moore JL, Roth EJ, Killian C, Hornby TG. Locomotor training improves daily stepping activity and gait efficiency in individuals poststroke who have reached a "plateau" in recovery. *Stroke* 2010;**41**(1):129-35.

Nilsson 2001 *{published and unpublished data}*

Hansen PD, Grimby G, Carlsson J, Nilsson L. Body-weight-support gait training. *Clinical Rehabilitation* 2002;**16**(3):343-5.

Nilsson L, Carlsson J, Danielsson A, Fugl-Meyer A, Hellstrom K, Kristensen L, et al. Walking training of patients with hemiparesis

at an early stage after stroke. 14th International Congress of The World Confederation for Physical Therapy; Barcelona (Spain). 2003:RR-PL-1729.

* Nilsson L, Carlsson J, Danielsson A, Fugl-Myer A, Hellstrom K, Kristensen L, et al. Walking training of patients with hemiparesis at an early stage after stroke: a comparison of walking training on a treadmill with body weight support and walking training on the ground. *Clinical Rehabilitation* 2001;**15**(5):515-27.

Nilsson 2001a *{published and unpublished data}*

Nilsson L, Carlsson J, Danielsson A, Fugl-Myer A, Hellstrom K, Kristensen L, et al. Walking training of patients with hemiparesis at an early stage after stroke: a comparison of walking training on a treadmill with body weight support and walking training on the ground. *Clinical Rehabilitation* 2001;**15**(5):515-27.

Nilsson 2001b *{published and unpublished data}*

Nilsson L, Carlsson J, Danielsson A, Fugl-Myer A, Hellstrom K, Kristensen L, et al. Walking training of patients with hemiparesis at an early stage after stroke: a comparison of walking training on a treadmill with body weight support and walking training on the ground. *Clinical Rehabilitation* 2001;**15**(5):515-27.

Olawale 2009 *{published data only}*

Olawale O, Appiah-Kubi K, Jones-Okai D. Exercise training improves walking function in an African group of stroke survivors: a randomized controlled trial. *Physiotherapy* 2007;**93**(Suppl 1):s562-3.

* Olawale OA, Jaja SI, Anigbogu CN, Appiah-Kubi KO, Jones-Okai D. Effects of two exercise training techniques on walking function in adult patients with stroke. *Nigerian Quarterly Journal of Hospital Medicine* 2009;**19**(2):88-94.

Olawale OA, Jaja SI, Anigbogu CN, Appiah-Kubi KO, Jones-Okai D. Exercise training improves walking function in an African group of stroke survivors: a randomized controlled trial. *Clinical Rehabilitation* 2011;**5**:442-50.

Park 2013 *{published data only}*

Park IM, Lee YS, Moon BM, Sim SM. A comparison of the effects of overground gait training and treadmill gait training according to stroke patients' gait velocity. *Journal of Physical Therapy Science* 2013;**25**:379-82.

Park 2015 *{published data only}*

Park J, Park S-Y, Kim Y-W, Woo Y. Comparison between treadmill training with rhythmic auditory stimulation and ground walking with rhythmic auditory stimulation on gait ability in chronic stroke patients: a pilot study. *NeuroRehabilitation* 2015;**37**:193-202.

Pohl 2002 *{published data only}*

Mehrholz J, Ritschel C, Ruckriem S, Pohl M. Speed-dependent treadmill training in hemiparetic stroke patients. A randomized controlled trial. 14th International Congress of The World Confederation for Physical Therapy; Barcelona (Spain). 2003:RR-PL-0168.

Pohl M, Mehrholz J, Ritschel C, Ruckriem S. Speed-dependent treadmill training in ambulatory hemiparetic stroke patients: a randomized controlled trial. *Neurorehabilitation and Neural Repair* 2001;**15**:311.

* Pohl M, Mehrholz J, Ritschel C, Ruckriem S. Speed-dependent treadmill training in ambulatory hemiparetic stroke patients: a randomized controlled trial. *Stroke* 2002;**33**:553-8.

Pohl M, Mehrholz J, Ritschel C, Ruckriem S. Speed-dependent treadmill training in ambulatory stroke patients: a randomized controlled trial. 3rd World Congress in Neurological Rehabilitation. Venice, Italy, 2002:T3.

Ribeiro 2013 *{published data only}*

Ribeiro T, Britto H, Oliveira D, Silva E, Galvao E, Lindquist A. Effects of treadmill training with partial body weight support and the proprioceptive neuromuscular facilitation method on hemiparetic gait: a randomized controlled study. *European Journal of Physical and Rehabilitation Medicine* 2013;**49**:451-61.

Richards 1993 *{published data only}*

Malouin F, Richards CL, Wood-Dauphinee S, Williams JI. Effects of an intense task-oriented gait-training program in acute stroke patients: a pilot study. In: Woollacott M, Horak F editor(s). Posture and Gait: Control Mechanisms. Portland (ORE): University of Oregon Books, 1992:407-10.

Malouin F, Richards CL, Wood-Dauphinee S, Williams JY. Effects of early and intensive gait training in stroke patients: a pilot study. *Physical Therapy* 1991;**71**(6):S58.

Malouin F, Richards Cl, Wood-Dauphinee S, Williams JI. A randomized controlled trial comparing early and intensive task-specific therapy to conventional therapy in acute-stroke patients. *Canadian Journal of Rehabilitation* 1993;**7**(1):27-8.

Malouin F, Richards Cl, Wood-Dauphinee S, Williams JI. Early standing and intensive locomotor training after stroke. International Congress on Stroke Rehabilitation. Berlin: German Society for Neurological Rehabilitation, 1993:41.

Richards CL, Malouin F. Evaluation and therapy of disturbed motor control in spastic paresis: therapeutic considerations for locomotor disorders. *Neurology Report* 1997;**21**:85-90.

* Richards CL, Malouin F, Wood-Dauphinee S, Williams JI, Bouchard JP, Brunet D. Task-specific physical therapy for optimization of gait recovery in acute stroke patients. *Archives of Physical Medicine & Rehabilitation* 1993;**74**(6):612-20.

Richards 2004 *{published data only}*

Richards CL, Malouin F, Bravo G, Dumas F, Wood-Dauphinee S. The role of technology in task-oriented locomotor training in acute stroke: a randomized controlled trial. 14th International Congress of The World Confederation for Physical Therapy; Barcelona (Spain). 2003:RR-PL-1592.

* Richards CL, Malouin F, Bravo G, Dumas F, Wood-Dauphinee S. The role of technology in task-oriented training in persons with subacute stroke: a randomized controlled trial. *Neurorehabilitation & Neural Repair* 2004;**18**(4):199-211.

Scheidtmann 1999 *{published and unpublished data}*

Scheidtmann K, Brunner H, Muller F, Weinandy-Trapp M, Wulf D, Koenig E. Treadmill training in early poststroke patients - do timing and walking ability matter? [Sequenzeffekte in der laufbandtherapie]. *Neurological Rehabilitation* 1999;**5**(4):198-202.

Smith 2008 *{published data only}*

Smith PS. The Effect of Treadmill Training on Functional Limitation and Disability Measures in Persons in the Chronic Stage of Recovery from Stroke [PhD Thesis]. Texas Woman's University, 2006.

* Smith PS, Thompson M. Treadmill training post stroke: are there any secondary benefits? A pilot study. *Clinical Rehabilitation* 2008;**22**(10-11):997-1002.

Srivastava 2016 *{published data only}*

Srivastava A, Taly AB, Gupta A, Kumar S, Murali T. Bodyweight-supported treadmill training for retraining gait among chronic stroke survivors: a randomized controlled study. *Annals of Physical and Rehabilitation Medicine* 2016;**59**:235-41.

Sullivan 2007 *{published data only}*

Carey JR. Locomotor and strength training in adults who were ambulatory after stroke: invited commentary. *Physical Therapy* 2007;**87**(12):1603-5.

Klassen T, Mulroy SJ, Sullivan KJ. Gait parameters associated with responsiveness to a task-specific and/or strength training program post-stroke. *Journal of Neurologic Physical Therapy* 2005;**29**(4):198.

Mulroy SJ, Klassen T, Gronley JK, Eberly VJ, Brown DA, Sullivan KJ. Gait parameters associated with responsiveness to treadmill training with body-weight support after stroke: an exploratory study. *Physical Therapy* 2010;**90**(2):209-23.

* Sullivan KJ, Brown DA, Klassen T, Mulroy S, Ge T, Azen SP, et al. Effects of task-specific locomotor and strength training in adults who were ambulatory after stroke: results of the STEPS randomized clinical trial. *Physical Therapy* 2007;**87**(12):1580-602.

Sullivan KJ, Brown DA, Mulroy S, Winstein CJ. Author response: Locomotor and strength training in adults who were ambulatory after stroke. *Physical Therapy* 2007;**87**(12):1605-7.

Suputtitada 2004 *{published data only}*

Suputtitada A, Yooktanan P, Rarerng-Ying T. Effect of partial body weight support treadmill training in chronic stroke patients. *Chotmaihet Thangphaet* 2004;**87 Suppl 2**:S107-11.

Takami 2010 *{published data only}*

Takami A, Wakayama S. Effects of partial body weight support while training acute stroke patients to walk backwards on a treadmill - a controlled clinical trial using randomized allocation. *Journal of Physical Therapy Science* 2010;**22**(2):177-87.

Toledano-Zarhi 2011 *{published data only}*

Toledano A, Katz-Leurer M, Carmeli E, Kamerman T, Merzeliak O, Adler Y, et al. A pilot randomized clinical trial of an early supervised aerobic exercise training program after minor ischemic strokes. *Stroke* 2009;**40**(4):e252.

* Toledano-Zarhi A, Tanne D, Carmeli E, Katz-Leurer M. Feasibility, safety and efficacy of an early aerobic rehabilitation program for patients after minor ischemic stroke: a pilot randomized controlled trial. *NeuroRehabilitation* 2011;**28**(2):85-90.

Visintin 1998 *{published and unpublished data}*

Barbeau H, Visintin M. Optimal outcomes obtained with body-weight support combined with treadmill training in stroke subjects. *Archives of Physical Medicine & Rehabilitation* 2003;**84**(10):1458-65.

Selzer ME, Zorowitz RD. Frontiers in neurorehabilitation: translating basic research into clinical advances. *Journal of Neurologic Rehabilitation* 1998;**12**:149-51.

* Visintin M, Barbeau H, Korner-Bitensky N, Mayo NE. A new approach to retrain gait in stroke patients through body weight support and treadmill stimulation. *Stroke* 1998;**29**(6):1122-8.

Visintin M, Korner-Bitensky N, Barbeau H, Mayo N. A new approach to retraining gait following stroke through body weight support and treadmill simulation. 12th International Congress of the World Confederation of Physical Therapy. Washington DC: American Physical Therapy Association, 1995:812.

Visintin 1998a *{published and unpublished data}*

Visintin M, Barbeau H, Korner-Bitensky N, Mayo NE. A new approach to retrain gait in stroke patients through body weight support and treadmill stimulation. *Stroke* 1998;**29**(6):1122-8.

Visintin 1998b *{published and unpublished data}*

Visintin M, Barbeau H, Korner-Bitensky N, Mayo NE. A new approach to retrain gait in stroke patients through body weight support and treadmill stimulation. *Stroke* 1998;**29**(6):1122-8.

Weng 2004 *{published data only}*

Weng CS, Bi S, Tian Z, Yu ZZ, Xu J, Bi SQ, et al. Application of structured speed-dependent treadmill training in hemiplegic patients after stroke. *Zhongguo Linchuang Kangfu* 2004;**8**(34):7617-9.

Weng 2006 *{published data only}*

Weng CS, Wang J, Pan XY, Yu ZZ, Wang G, Gao LP, et al. Effectiveness of backward walking treadmill training in lower extremity function after stroke. *Zhonghua Yi Xue Za Zhi* 2006;**86**(37):2635-8.

Werner 2002a *{published and unpublished data}*

Hesse S, Werner C, Bardeleben A, Von Frankenberg S. Treadmill therapy with partial body weight support and an automated gait trainer for restoration of gait after stroke: a randomized study. 3rd World Congress in Neurological Rehabilitation. Venice (Italy), 2002:T1.

Hesse S, Werner C, Bardeleben A, Von Frankenberg S. Treadmill therapy with partial body weight support and an automated gait trainer for restoration of gait after stroke: a randomized study. *Neurorehabilitation & Neural Repair* 2001;**15**:310-1.

Hesse S, Werner C, Von Frankenberg S, Bardeleben A. Electromechanical gait trainer for restoration of gait after stroke. 1st World Congress of the International Society of Physical Rehabilitation Medicine (ISPRM); 2001 July 7-13. 2001:489-94.

* Werner C, Von Frankenberg S, Treig T, Konrad M, Hesse S. Treadmill training with partial body weight support and an electromechanical gait trainer for restoration of gait in subacute stroke patients: a randomized crossover study. *Stroke* 2002;**33**:2895-901.

Yang 2010 *{published data only}*

Yang YR, Chen IH, Liao KK, Huang CC, Wang RY. Cortical reorganization induced by body weight-supported treadmill training in patients with hemiparesis of different stroke durations. *Archives of Physical Medicine and Rehabilitation* 2010;**91**(4):513-8.

Yen 2008 *{published data only}*

Yen CL, Wang RY, Liao KK, Huang CC, Yang YR. Gait training induced change in corticomotor excitability in patients with chronic stroke. *Neurorehabilitation & Neural Repair* 2008;**22**(1):22-30.

Zhang 2008 *{published data only}*

* Zhang J-P, Wang J-H, Cao P-W, Chen M. The effect of body weight supported treadmill training on drop foot of hemiplegia. *Sichuan Medical Journal* 2008;**10**:1331-4.

Zhang J-P, Wang J-H, Chen W, Liu D-Y. The effect of body-weight supported treadmill training on drop foot of hemiplegia. *Journal of Rehabilitation Medicine* 2008;**46**(Suppl):104.

Zhu 2004 *{published data only}*

Zhu HX, Dou ZL, Li K, Lan Y, Hu XQ. A preliminary investigation on the correlation of partial body weight support training with hemiplegic gait and ambulation function after brain injury. *Zhongguo Linchuang Kangfu* 2004;**8**(25):5205-7.

References to studies excluded from this review

Aschbacher 2006 *{published data only}*

Aschbacher B. Comparing gait training in patients after stroke with task oriented physiotherapy or robot-assisted treadmill training, a feasibility study (as supplied prior to 14 July 2017). Data on file 2006.

Bayat 2005 *{published data only}*

Bayat R, Barbeau H, Lamontagne A. Speed and temporal-distance adaptations during treadmill and overground walking following stroke. *Neurorehabilitation & Neural Repair* 2005;**2**:115-24.

Bleckert 2006 *{published data only}*

Bleckert MG, Felder H, Grunebert C. Treadmill therapy in the acute rehabilitation stage in hemiparetic patients [Laufbandtherapie in der akuten rehabilitationsphase bei patienten mit hemiparese. Pilotstudie zum vergleich lansamer und schneller ganggeschwindigkeiten]. *Physioscience* 2006;**2**(2):67-72.

Blennerhassett 2004 *{published data only}*

Blennerhassett J, Dite W. A randomised controlled trial evaluating additional task-related practice during stroke rehabilitation. *Australian Journal of Physiotherapy* 2003;**49**(4 Suppl):s6-7.

* Blennerhassett J, Dite W. Additional task-related practice improves mobility and upper limb function early after stroke: a randomised controlled trial. *Australian Journal of Physiotherapy* 2004;**50**(4):219-24.

Borsje 2003 *{unpublished data only}*

Borsje S, Hochstenbach JBH, Postema K, Mulder TH. Clinical value of motor imagery and bodyweight supported treadmill training for recovery of gait performance of stroke patients in the early phase. European Stroke Conference; 2003 May 21-24. Valencia (Spain), 2003.

Brissot 2006 *{published data only}*

NCT00284115. Efficacy of a mechanical gait repetitive training technique in hemiparetic stroke patients. clinicaltrials.gov (first received 30 January 2006).

Caldwell 2000 *{unpublished data only}*

Caldwell C, Medley A. Effects of bicycling, treadmill, and variable surfaces on gait in people following a CVA. *Neurology Report* 2000;**24**(5):203.

Daly 2004 *{published data only}*

Daly JJ, Roenigk K, Holcomb J, Rogers JM, Butler K, Gansen J, et al. A randomized controlled trial of functional neuromuscular stimulation in chronic stroke subjects. *Stroke* 2006;**37**(1):172-8.

* Daly JJ, Roenigk KL, Butler KM, Gansen JL, Fredrickson E, Marsolais EB, et al. Response of sagittal plane gait kinematics to weight-supported treadmill training and functional neuromuscular stimulation following stroke. *Journal of Rehabilitation Research & Development* 2004;**41**(6):807-20.

Daly JJ, Rogers J, Strasshofer B, Debogorski AA, Roenigk K, Ruff RL. Treadmill training, weight support, and FNS for stroke gait training. Platform and poster presentations for CSM 2003. *Neurology Report* 2002;**26**(4):202-3.

Daly JJ, Ruff RL. Feasibility of combining multi-channel functional neuromuscular stimulation with weight-supported treadmill training. *Journal of the Neurological Sciences* 2004;**225**(1-2):105-15.

Daly JJ, Sng K, Roenigk K, Fredrickson E, Dohring M. Intra-limb coordination deficit in stroke survivors and response to treatment. *Gait & Posture* 2007;**25**(3):412-8.

Hansen K, Lucarelli J, Torres AM, Roenigk KL, Daly JJ. Muscle activation latency gains for gait, in response to combined treadmill training, weight support, and FNS following stroke. National Science Conference, American Physical Therapy Association; 2003 February; Tampa, Florida, USA. 2003.

NCT0001196. FNS and weight support treadmill training for gait component restoration. clinicaltrials.gov (first received 22 February 2001).

Pundik S, Holcomb J, Daly JJ. Improvements in life-role participation after intensive gait training of chronic stroke survivors. *Stroke* 2009;**40**(4):e123.

Daly 2011 *{published data only}*

Daly J, Zimbelman J, Roenigk K, McCabe J, Rogers J, Butler K, et al. Recovery of coordinated gait: randomized controlled stroke trial of functional electrical stimulation (FES) versus no FES, with weight-supported treadmill and over-ground training. *Neurorehabilitation & Neural Repair* 2011;**25**(7):588-96.

Dean 2000 *{published and unpublished data}*

* Dean CM, Richards CL, Malouin F. Task-related circuit training improves performance of locomotor tasks in chronic stroke: a randomized, controlled pilot study. *Archives of Physical Medicine & Rehabilitation* 2000;**81**(4):409-17.

Richards CL. Task-oriented gait training for patients with cerebral palsy and stroke. 2nd World Congress in Neurological Rehabilitation. Toronto, 1999:218-27.

Richards CL, Malouin F, Dean C. Maximizing locomotor recovery after stroke. *Archives of Physiology & Biochemistry* 2000;**108**(1-2):1.

DEGAS 2007 *{published data only}*

* Mehrholz J, Werner C, Hesse S, Pohl M. Immediate and long-term functional impact of repetitive locomotor training as an adjunct to conventional physiotherapy for non-ambulatory patients after stroke. *Disability and Rehabilitation* 2008;**30**(11):830-6.

Pohl M, Mehrholz J, Rutte K, Dressler C, Gold S, Werner C, et al. Results of aerobic exercise training in patients after stroke. Gait trainer vs conventional therapy. A randomized controlled longitudinal study. First results. *Neurologie und Rehabilitation* 2003;**9**(6):S6-7.

Pohl M, Mehrholz J, Werner C, Hesse S. Comparison of aerobic exercise training in patients after stroke - gait trainer versus conventional physiotherapy. A randomized controlled longitudinal study [Vergleich der aeroben ubungsintensitat bei patienten nach schlaganfall - gangtrainer versis konventionelle physiotherapie. Eine randomisierte and kontrollierte longitudinalstudie]. *Neurologie und Rehabilitation* 2004;**10**(4):187-216.

Pohl M, Werner C, Holzgraefe M, Kroczek G, Mehrholz J, Wingendorf I, et al. Repetitive locomotor training and physiotherapy improve walking and basic activities of daily living after stroke: a single-blind, randomized multicentre trial (DEutsche GAngtrainerStudie, DEGAS). *Clinical Rehabilitation* 2007;**21**(1):17-27.

Werner C, Pohl M, Holzgraefe M, Kroczek G, Mehrholz J, Wingendorf I, et al. 'DEGAS' - German gait training study to evaluate the gait trainer (GT1) combined with physiotherapy compared with physiotherapy alone in acute stroke patients. *Neurologie und Rehabilitation* 2004;**10**(4):187-216.

Werner C, Pohl M, Holzgraefe M, Kroczek G, Mehrholz J, Wingendorf I, et al. Design of a multicentre study. *Neurologie und Rehabilitation* 2003;**9**(6):S6.

Werner C, Pohl M, Holzgraefe M, Kroczek G, Mehrholz J, Wingendorf I, et al. Locomotor training in subacute stroke patients: results of a multicenter study (DEGAS). *Neurologie und Rehabilitation* 2006;**12**(5):262-9.

Dias 2007 *{published data only}*

* Dias D, Lains J, Pereira A, Nunes R, Caldas J, Amaral C, et al. Can we improve gait skills in chronic hemiplegics? A randomised control trial with gait trainer. *Europa Medicophysica* 2007;**43**(4):499-504.

Dias D, Lains J, Pereira A, Nunes R, Caldas J, Amaral C, et al. Partial body weight support in chronic hemiplegics: a randomized control trial. 6th Mediterranean Congress of Physical and Rehabilitation Medicine; 2006 October 18-21; Vilamoura, Portugal. 2006.

Druzbicki 2016 *{published data only}*

Druzbicki M, Przysada G, Guzik A, Kwolek A, Brzozowska-Magon A, Sobolewski M. Evaluation of the impact of exercise of gait on a treadmill on balance of people who suffered from cerebral stroke. *Acta of Bioengineering and Biomechanics* 2016;**18**:41-8.

English 2007 *{published data only}*

English CK, Hillier SL, Stiller KR, Warden-Flood A. Circuit class therapy versus individual physiotherapy sessions during inpatient stroke rehabilitation: a controlled trial. *Archives of Physical Medicine and Rehabilitation* 2007;**88**(8):955-63. [0003-9993: (Print)]

Fisher 2008 *{published data only}*

Fisher S. Use of Autoambulator for mobility improvement in patients with central nervous system (CNS) injury or disease. *Neurorehabilitation & Neural Repair* 2008;**22**(5):556.

Forrester 2004 *{published data only}*

Forrester LW, Villagra F, Macko RF, Hanley DF. Treadmill vs. stretching: short-term CNS adaptations to single bouts of submaximal exercise in chronic stroke patients. *Stroke* 2004;**35**(6):e312.

Freivogel 2009 *{published data only}*

Freivogel S, Schmalohr D, Mehrholz J. Improved walking ability and reduced therapeutic stress with an electromechanical gait device. *Journal of Rehabilitation Medicine* 2009;**41**(9):734-9.

Globokar 2005 *{published data only}*

Globokar D. Gait trainer in neurorehabilitation of patients after stroke. 3rd World Congress of the International Society of Physical and Rehabilitation Medicine - ISPRM; 2005 April 10-14; Sao Paulo, Brazil. 2005.

Hidler 2009 *{published data only}*

Hidler J, Hornby G. Gait restoration in hemiparetic stroke patients using goal-directed robotic-assisted treadmill training. www.ric.org/research/clinical-trials/detail/?id=169 (first accessed prior to 14 July 2017).

* Hidler J, Nichols D, Pelliccio M, Brady K, Campbell DD, Kahn JH, et al. Multicenter randomized clinical trial evaluating the effectiveness of the Lokomat in subacute stroke. *Neurorehabilitation & Neural Repair* 2009;**23**(1):5-13.

NCT00075283. Walking therapy in hemiparetic stroke patients using robotic-assisted treadmill training. clinicaltrials.gov (first received 8 January 2004).

Hornby 2008 *{published data only}*

Anonymous. Enhanced gait-related improvements after therapist-versus robotic-assisted locomotor training in subjects with chronic stroke: a randomized controlled study. Stroke 2008; Vol. 39, issue 8:e143.

* Hornby TG, Campbell DD, Kahn JH, Demott T, Moore JL, Roth HR. Enhanced gait-related improvements after therapist - versus robotic-assisted locomotor training in subjects with chronic stroke: a randomized controlled study. *Stroke* 2008;**39**(6):1786-92.

Kahn J, Campbell D, Demott T, Moore J, Roth H, Hornby G. Alterations in locomotor performance in individuals with hemiplegia post-stroke following robotic- or therapist-assisted locomotor training. *Journal of Neurologic Physical Therapy* 2006;**30**(4):212.

Lewek M, Hayes T, Moore J, Roth H, Hornby TG. Alterations in joint kinesmatics following locomotor training in individuals with chronic stroke. Platforms, thematic posters, and posters for CSM 2007. *Journal of Neurologic Physical Therapy* 2006;**30**(4):196.

Lewek MD, Cruz TH, Moore JL, Roth HR, Dhaher YY, Hornby TG. Allowing intralimb kinematic variability during locomotor training poststroke improves kinematic consistency: a subgroup analysis from a randomized clinical trial. *Physical Therapy* 2009;**89**(8):829-39.

Husemann 2007 *{published data only}*

* Husemann B, Muller F, Krewer C, Heller S, Koenig E. Effects of locomotion training with assistance of a robot-driven gait orthosis in hemiparetic patients after stroke: a randomized controlled pilot study. *Stroke* 2007;**38**(2):349-54.

Husemann B, Muller F, Krewer C, Lab A, Gille C, Heller S, et al. Effects of locomotion training with assistance of a driven gait orthosis in hemiparetic patients after stroke. *Neurologie und Rehabilitation* 2004;**10**(4):187-217.

Jang 2005 *{published data only}*

Jang SJ, Park SW, Kim ES, Wee HM, Kim YH. Electromechanical gait trainer for restoring gait in hemiparetic stroke patients. 3rd World Congress of the International Society of Physical and Rehabilitation Medicine - ISPRM; 2005 April 10-14; Sao Paulo, Brazil. 2005.

Jeong 2008 *{published data only}*

Jeong K, Ha H, Shin H, Ohn S, Sung D, Lee P, et al. Effects of robot-assisted gait therapy on locomotor recovery in stroke patients. *Journal of Rehabilitation Medicine* 2008;**40**(Suppl 46):148.

Khanna 2003 *{unpublished data only}*

Khanna PB. A randomised control study of the immediate and long term benefits of conventional stroke rehabilitation with task related group therapy in chronic stroke patients. www.controlled-trials.com/ (first received):CRSREF 2704239.

Kim 2001 *{unpublished data only}*

Kim BO, Lee JJ, Cho KH, Kim SH. Gait training robot (gaitTrainer) in rehabilitation. 1st International Congress of International Society of Physical and Rehabilitation Medicine (ISPRM); 2001 July 7-13; Amsterdam, Netherlands. International Society of Physical and Rehabilitation Medicine (ISPRM), 2001.

Kim 2008 *{published data only}*

Kim M, Kim Y, Lee P, Kim G, You J, Huh J. Effect of robot-assisted gait therapy on cardio-pulmonary fitness in subacute stroke patients. *Neurorehabilitation & Neural Repair* 2008;**22**(5):594.

Kovrazhkina 2009 *{published data only}*

Kovrazhkina E, Rumianzeva N, Starizin A, Ivanova G. Rehabilitation of walking in patients with an acute stroke with assistance of a robotic device gait trainer. *Cerebrovascular Diseases* 2009;**27**(Suppl 6):210.

Skvortsova V, Ivanova G, Kovrazhkina E, Rumyantseva N, Staritsin A, Sogomonyan E. The efficacy of gait rehabilitation after stroke training with assistance of a robotic device gait trainer: a pilot study. *International Journal of Stroke* 2008;**3**(Suppl):355.

Skvortsova VI, Ivanova GE, Kovrazhkina EA, Rumiantseva NA, Staritsyn AN, Suvorov A, et al. The use of a robot-assisted Gait Trainer GT1 in patients in the acute period of cerebral stroke: a pilot study. *Zh Nevrol Psikhiatr Im S S Korsakova* 2008;**Suppl 23**:28-34.

* Skvortsova VI, Ivanova GE, Rumiantseva NA, Staritsyn AN, Kovrazhkina EA, Suvorov A. Modern approach to gait restoration in patients in the acute period of cerebral stroke. *Zh Nevrol Psikhiatr Im S S Korsakova* 2010;**110**(4):25-30.

Kwakkel 1999 *{published data only}*

Kwakkel G, Kollen BJ, Wagenaar RC. Long term effects of intensity of upper and lower limb training after stroke: a randomised trial. *Journal of Neurology, Neurosurgery, and Psychiatry* 2002;**72**(4):473-9.

Kwakkel G, Wagenaar RC. Effect of duration of upper- and lower-extremity rehabilitation sessions and walking speed on recovery of interlimb co-ordination in hemiplegic gait. *Physical Therapy* 2002;**82**:432-48.

* Kwakkel G, Wagenaar RC, Twisk JWR, Lankhorst GJ, Koetsier JC. Intensity of leg and arm training after primary middle-cerebral-artery stroke: a randomised trial. *Lancet* 1999;**354**:191-6.

Langhammer 2000 *{published data only}*

Langhammer B, Stanghelle JK. Bobath or motor relearning programme? A comparison of two different approaches of physiotherapy in stroke rehabilitation: a randomized controlled study. *Clinical Rehabilitation* 2000;**14**:361-9.

Langhammer 2007 *{published data only}*

Langhammer B, Lindmark B, Stanghelle JK. Living with stroke: exercising for life. *Journal of Aging & Physical Activity* 2008;**16**:S80.

Langhammer B, Lindmark B, Stanghelle JK. Stroke patients and long-term training: is it worthwhile? A randomized comparison of two different training strategies after rehabilitation. *Clinical Rehabilitation* 2007;**21**(6):495-510.

Langhammer B, Lindmark B, Tanghelle JKS. Motor function, activity and participation one year post stroke: a l follow-up of a randomised controlled trial in persons with stroke. *Brain Injury* 2010;**24**(3):171-2.

Langhammer B, Stanghelle JK, Lindmark B. An evaluation of two different exercise regimes during the first year following stroke: a randomised controlled trial. *Physiotherapy Theory and Practice* 2009;**25**(2):55-68.

* Langhammer B, Stanghelle JK, Lindmark B. Exercise and health-related quality of life during the first year following acute stroke. A randomized controlled trial. *Brain Injury* 2008;**22**(2):135-45.

Lau 2010 *{published data only}*

* Lau KW, Mak MK. Speed-dependent treadmill training is effective to improve gait and balance performance in patients with sub-acute stroke. *Journal of Rehabilitation Medicine* 2011;**43**(8):709-13.

Lau WK, Mak MKY. The effects of speed-dependent treadmill training on gait and balance performance in patients with sub-acute stroke. *Hong Kong Physiotherapy Journal* 2010;**28**(1):27.

Lee 2013 *{published data only}*

Lee HJ, Cho KH, Lee WH. The effects of body weight support treadmill training with power-assisted functional electrical stimulation on functional movement and gait in stroke patients. *American Journal of Physical Medicine and Rehabilitation* 2013;**92**:1051-9.

Lindquist 2011 *{published data only}*

Lindquist A, Ribeiro T, Silva E, Galvao E. Influence of treadmill training with body weight support and proprioceptive neuromuscular facilitation on hemiparetic gait. *Archives of Physical Medicine and Rehabilitation* 2011;**92**(10):1718.

Macko 2006 *{published data only}*

Macko RF. Exercise training for hemiparetic stroke. crisp.cit.nih.gov/ (accessed prior to 14 July 2017).

* NCT00430456. Treadmill exercise prescriptions to improve fitness versus ambulatory function after stroke. clinicaltrials.gov/show/NCT00430456 (first received 31 January 2007).

Mayr 2007 *{published data only}*

Mayr A, Kofler M, Quirbach E, Matzak H, Frohlich K, Saltuari L. Prospective, blinded, randomized crossover study of gait rehabilitation in stroke patients using the Lokomat gait orthosis. *Neurorehabilitation & Neural Repair* 2007;**21**(4):307-14.

Mayr 2008 *{published data only}*

Mayr A, Saltuari L, Quirbach E. Impact of Lokomat training on gait rehabilitation: a prospective randomized controlled trial in stroke patients. *Neurorehabilitation & Neural Repair* 2008;**22**(5):596.

McCain 2008 *{published data only}*

McCain KJ, Pollo FE, Baum BS, Coleman SC, Baker S, Smith PS. Locomotor treadmill training with partial body-weight support before overground gait in adults with acute stroke: a pilot study. *Archives of Physical Medicine and Rehabilitation* 2008;**89**(4):684-91.

Michael 2011 *{published data only}*

* Michael KM. Combined adaptive physical activity and treadmill training in stroke. *Stroke* 2011;**42**(3):e355.

NCT01042990. Testing adaptive physical activity in stroke. clinicaltrials.gov/show/NCT01042990 (accessed 2 September 2013).

NCT00018421 *{published data only}*

NCT00018421. Effects of exercise on patients with hemiparetic stroke. www.clinicaltrials.gov (first received 3 July 2001).

NCT00108030 *{published data only}*

NCT00108030. PBWST (Partial body-weight supported treadmill training) and muscle power training after sub-acute stroke. clinicaltrials.gov/ct2/show/NCT00108030 (first received 12 April 2005).

NCT00284115 *{published data only}*

NCT00284115. Efficacy of a mechanical gait repetitive training technique in hemiparetic stroke patients (AVC). www.clinicaltrials.gov (first received 30 January 2006).

NCT00612300 *{published data only}*

NCT00612300. Gait training for persons with stroke (GTS). clinicaltrials.gov. (first received 28 January 2008).

NCT00891514 *{published data only}*

NCT00891514. Inflammation and exercise in stroke. www.clinicaltrials.gov (first received 30 April 2009).

NCT01146587 *{published data only}*

NCT01146587. Comparative study of GangTrainer GT1, Lokomat and conventional physiotherapy. www.clinicaltrials.gov (first received 14 June 2010).

NCT01337960 *{published data only}*

NCT01337960. Ankle robotics training after stroke. clinicaltrials.gov/show/NCT01337960 (first received 15 April 2011).

NCT01674790 *{published data only}*

NCT01674790. Combined effects of aerobic exercise and cognitive training on cognition after stroke. www.clinicaltrials.gov (first received 24 August 2012).

NCT02043574 *{published data only}*

NCT02043574. Nutrition and aerobic exercise in chronic stroke. www.clinicaltrials.gov (first received 6 January 2014).

NCT02680496 *{published data only}*

NCT02680496. Energy consumption and cardiorespiratory load during walking with and without robot-assistance. www.clinicaltrials.gov (first received 27 January 2016).

NCT02735148 *{published data only}*

NCT02735148. The effects of body weight supported treadmill training on balance in stroke patients. www.clinicaltrials.gov (first received 30 March 2016).

NCT02798237 *{published data only}*

NCT02798237. Effects of aerobic training post-stroke. www.clinicaltrials.gov (first received 6 June 2016).

NCT02956096 *{published data only}*

NCT02956096. Evaluation of autonomic modulation in stroke after transcranial direct current stimulation and treadmill training. www.clinicaltrials.gov (first received 30 September 2016).

NCT03006731 *{published data only}*

NCT03006731. High intensity interval training for people with stroke deficits. www.clinicaltrials.gov (first received 19 December 2016).

NCT03056287 *{published data only}*

NCT03056287. Exercise and brain stimulation for post-stroke depression. www.clinicaltrials.gov (first received 8 February 2017).

Pang 2010 *{published data only}*

Pang MYC, Lau RWK. The effects of treadmill exercise training on hip bone density and tibial bone geometry in stroke survivors: a pilot study. *Neurorehabilitation & Neural Repair* 2010;**24**(4):368-76.

Park 2012 *{published data only}*

Park SE, Kim SH, Lee SB, An HJ, Choi WS, Moon OG, et al. Comparison of underwater and overground treadmill walking to improve gait pattern and muscle strength after stroke. *Journal of Physical Therapy Science* 2012;**24**(11):1087-90.

Peurala 2005 *{published data only}*

Peurala SH, Pitkanen K, Sivenius J, Tarkka I. Body-weight supported gait exercise compared with floor walking in chronic stroke patients. *Archives of Physical Medicine & Rehabilitation* 2004;**85**(9):E7.

* Peurala SH, Tarkka IM, Pitkanen K, Sivenius J. The effectiveness of body weight-supported gait training and floor walking in patients with chronic stroke. *Archives of Physical Medicine & Rehabilitation* 2005;**86**(8):1557-64.

Pitkanen K, Tarkka I, Sivenius J. Walking training with partial body weight support versus conventional walking training of chronic stroke patients: preliminary findings. *Neurorehabilitation & Neural Repair* 2001;**15**(4):312.

Pitkanen K, Tarkka IM, Sivenius J. Walking training with partial body weight support versus conventional walking training of chronic stroke patients: preliminary findings. 3rd World Congress in Neurological Rehabilitation; Venice, Italy. 2002:T7.

Peurala 2009 *{published data only}*

NCT00307762. Gait trainer vs traditional physiotherapy in acute stroke. clinicaltrials.gov (first received 27 March 2006).

Peurala S, Airaksinen O, Jakala P, Tarkka I, Sivenius J. Intensive walking and exercise therapy during early acute stage of stroke. 18th International Conference of the International Society for Posture and Gait Research; Vermont, USA. 2007:103-4.

* Peurala SH, Airaksinen O, Huuskonen P, Jakala P, Juhakoski M, Sandell K, et al. Effects of intensive therapy using gait trainer or floor walking exercises early after stroke. *Journal of Rehabilitation Medicine* 2009;**41**(3):166-73.

Peurala SH, Airaksinen O, Jakala P, Tarkka IM, Sivenius J. Effects of intensive gait-oriented physiotherapy during early acute phase of stroke. *Journal of Rehabilitation Research and Development* 2007;**44**(5):637-48.

Peurala SH, Pitkanen K, Sivenius J, Tarkka IM. Body-weight supported gait trainer exercises with or without functional electrical stimulation improves gait in patients with chronic stroke. *Neurorehabilitation & Neural Repair* 2006;**20**(1):98.

Ploughman 2008 *{published data only}*

Ploughman M, McCarthy J, Bosse M, Sullivan HJ, Corbett D. Does treadmill exercise improve performance of cognitive or upper-extremity tasks in people with chronic stroke? A randomized cross-over trial. *Archives of Physical Medicine and Rehabilitation* 2008;**89**(11):2041-7.

Rimmer 2000 *{published data only}*

Rimmer JH, Riley B, Creviston T, Nicola T. Exercise training in a predominantly African-American group of stroke survivors. *Medicine & Science in Sports & Exercise* 2000;**32**:1990-6.

Salbach 2004 *{published data only}*

Salbach NM, Mayo NE, Robichaud-Ekstrand S, Hanley JA, Richards CL, Wood-Dauphinee S. The effect of a task-oriented walking intervention on improving balance self-efficacy poststroke: a randomized, controlled trial. *Journal of the American Geriatrics Society* 2005;**53**(4):576-82. [MEDLINE: 15817001]

* Salbach NM, Mayo NE, Wood-Dauphinee S, Hanley JA, Richards CL, Cote R. A task-orientated intervention enhances walking distance and speed in the first year post stroke: a randomized controlled trial. *Clinical Rehabilitation* 2004;**18**(5):509-19.

Saltuari 2004 *{published data only}*

Saltuari L. Efficiency of Lokomat training in stroke patients. *Neurologie und Rehabilitation* 2004;**10**(4):169-78.

Schwartz 2009 *{published data only}*

Schwartz I, Katz-Leurer M, Fisher I, Sajin A, Shochina M, Meiner Z. The effectiveness of early locomotor therapy in patients with first CVA. Collaborative Evaluation of Rehabilitation in Stroke Across Europe (CERISE) Congress; 2006 February 10-11. 2006.

* Schwartz I, Sajin A, Fisher I, Neeb M, Shochina M, Katz-Leurer M, et al. The effectiveness of locomotor therapy using robotic-assisted gait training in subacute stroke patients: a randomized controlled trial. *Physical Medicine and Rehabilitation* 2009;**1**(6):516-23.

Shafshak 2012 *{published data only}*

* Shafshak TS. Central neuroplasticity and upper limbs functional outcome following repetitive lower limb locomotor training in stroke patients. *Physical Medicine and Rehabilitation* 2012;**10**:S298.

Shahine EM, Shafshak TS. Central neuroplasticity and upper limbs functional outcome following repetitive lower limb locomotor training in chronic stroke patients. *European Journal of Neurology* 2012;**19**:570.

Sullivan 2002 *{published data only}*

* Sullivan KJ, Knowlton BJ, Dobkin BH. Step training with body weight support: effect of treadmill speed on practice paradigms on poststroke locomotor recovery. *Archives of Physical Medicine & Rehabilitation* 2002;**83**:683-91.

Sullivan KJ, Knowlton BJ, Dobkin BH. The effect of varying treadmill speed to enhance overground walking in patients with chronic stroke. *Stroke* 2000;**31**(1):292.

Sullivan KJ, Knowlton BJ, Dobkin H. Stroke severity and treadmill training as predictors of locomotor recovery in chronic stroke. *Neurology Report* 2000;**24**(5):173-4.

Tong 2006 *{published data only}*

Li LSW. Motor training after stroke. *Journal of Neurology, Neurosurgery, and Psychiatry* 2005;**76**(4):605-6.

Li LSW, Tong RKY, Ng MFW, So EFM. Gait training by mechanical gait trainer and functional electrical stimulation for subacute stroke patients: a randomised controlled study. 3rd World Congress of the International Society of Physical and Rehabilitation Medicine - ISPRM; 2005 10-14 April; Sao Paulo, Brazil. 2005.

Li LSW, Tong RYU, Ng MFW, So EFM. Effectiveness of gait trainer in stroke rehabilitation. *Journal of the Neurological Sciences* 2005;**238 Suppl 1**:S81.

Ng MF, Tong RK, Li LS. A pilot study of randomized clinical controlled trial of gait training in subacute stroke patients with partial body-weight support electromechanical gait trainer and functional electrical stimulation: six-month follow-up. *Stroke* 2008;**39**(1):154-60.

Ng MFW, Tong KY, So EFM, Li LSW. The therapeutic effect of electromechanical gait trainer and functional electrical stimulation for patients with acute stroke. *Neurorehabilitation & Neural Repair* 2006;**20**(1):97.

Tong R, Ng M, Li L. The effect of electromechanical gait trainer combined with functional electrical stimulation for subacute stroke rehabilitation. *International Journal of Stroke* 2008;**3**(Suppl):357.

* Tong RK, Ng MF, Li LS. Effectiveness of gait training using an electromechanical gait trainer, with and without functional electric stimulation, in subacute stroke: a randomized controlled trial. *Archives of Physical Medicine and Rehabilitation* 2006;**87**(10):1298-304.

Trueblood 2001 *{published data only}*

Trueblood PR. Partial body weight treadmill training in persons with chronic stroke. *Neurorehabilitation* 2001;**16**:141-53.

Tsai 2004 *{published data only}*

Tsai YC, Yang S, Chern JS. Effect of backward-walk training in proving the balance and weight shifting skill of stroke patients. *Stroke* 2004;**35**(6):e319.

Tsang 2012 *{published data only}*

Tsang MYC, Eng JJ, Tang A, Jue J, Gin KG, Nair P, et al. Impact of aerobic exercise training on cardiac function in stroke patients: a prospective randomized controlled study. *Journal of the American Society of Echocardiography* 2012;**25**(6):B11.

Werner 2002b *{published and unpublished data}*

Bardeleben A, Schaffrin A, Werner C, Hesse S. Treadmill therapy with and without physiotherapy after stroke: a randomized trial [Laufbandtherapie mit und ohne physiotherapie nach schlaganfall: eine randomisierte studie]. Deutsche Gesellschaft fur Neurologische Rehabilitation Annual Conference; 2000 November 23-25. 2000.

Hesse S, Lucke D, Bardeleben A. Chronic nonambulatory hemiparetic subjects: effects of a treadmill training alone and in combination with regular physiotherapy. 2nd World Congress in Neurological Rehabilitation. Toronto, Canada, 1999.

Hesse S, Lucke D, Bardeleben A. Chronic nonambulatory hemiplegic subjects: effects of a treadmill training alone and in combination with regular physiotherapy. *Neurorehabilitation & Neural Repair* 1999;**13**(1):54.

* Werner C, Bardeleben A, Mauritz KH, Kirker S, Hesse S. Treadmill training with partial body weight support and physiotherapy in stroke patients: a preliminary comparison. *European Journal of Neurology* 2002;**9**:639-44.

Westlake 2009 *{published data only}*

Patten C. Internally versus externally guided body weight supported treadmill training [BWSTT] for locomotor recovery post-stroke. www.strokecenter.org/trials/ (accessed prior to 14 July 2017).

* Westlake KP, Patten C. Pilot study of Lokomat versus manual-assisted treadmill training for locomotor recovery post-stroke. *Journal of NeuroEngineering and Rehabilitation* 2009;**6**:18.

Yagura 2006 *{published data only}*

Yagura H, Hatakenaka M, Miyai I. Does therapeutic facilitation add to locomotor outcome of body weight-supported treadmill

training in nonambulatory patients with stroke? A randomized controlled trial. *Archives of Physical Medicine and Rehabilitation* 2006;**87**(4):529-35.

Yang 2008 *{published data only}*

* Yang S, Hwang W-H, Tsai Y-C, Liu F-K, Hsieh L-F, Chern J-S. Improving balance skills in patients who had stroke through virtual reality treadmill training. *American Journal of Physical Medicine & Rehabilitation* 2011;**90**(12):969-78.

Yang YR, Tsai MP, Chuang TY, Sung WH, Wang RY. Virtual reality-based training improves community ambulation in individuals with stroke: a randomized controlled trial. *Gait & Posture* 2008;**28**(2):201-6.

References to studies awaiting assessment

Baer 2009 *{published data only}*

Baer G. Treadmill training and sub-acute stroke: a phase II feasibility study. 3rd UK Stroke Forum Conference; Harrogate, UK. 2008:21.

* Baer G, Dennis M, Pitman J, Salisbury L, Smith M. Does treadmill training improve walking after stroke - the long term follow-up from a phase II randomised controlled trial. *International Journal of Stroke* 2009;**4**(Suppl 2):8.

Salisbury L, Baer G, Dennis M, Pitman J, Smith M. Does treadmill training affect activities of daily living or quality of life after stroke? Results of a phase II randomised controlled trial. *International Journal of Stroke* 2009;**4 Suppl 2**:38.

Smith M, Baer G, Dennis M, Pitman J, Salisbury L. How feasible is the delivery of treadmill training early after stroke within the NHS: findings of a phase II randomised controlled trial. *International Journal of Stroke* 2009;**4 Suppl 2**:38.

Statt TC. Treadmill training in sub-acute stroke: report of an ongoing phase II feasibility study of a complex intervention. UK Stroke Forum Conference 2007; Harrogate, UK. 2007.

Bartloff 2009 *{published data only}*

Bartloff J, Bitting J, Lueke A, Sbertoli C, Sofen L, Walsh J, et al. After-effects of slow isokinetic walk speed training on self-selected gait velocity in persons with chronic post-stroke hemiparesis. Journal of Neurologic Physical Therapy 2009; Vol. 33, issue 4:231.

Mokrusch 2004 *{published data only}*

Mokrusch T, Busch K. Treadmill training with functional electric stimulation in stroke patients. Benefits compared with Bobath physiotherapy. Neurologie und Rehabilitation. Hippocampus, 2004; Vol. 10, issue 4:187-216.

Muller 2004 *{published data only}*

Muller F, Heller S, Krewer C, Husemann B, Koenig E. Effective gait training on the treadmill and the Lokomat: comparison of achievable training time and speed. Neurologie und Rehabilitation. Hippocampus, 2004; Vol. 10, issue 4:187-216.

NCT01789853 *{published data only}*

NCT01789853. Very intensive early walking in stroke. clinicaltrials.gov/show/NCT01789853 (first received 14 May 2012).

NCT02619110 *{published data only}*

NCT02619110. The effect of backward walking treadmill training on balance in patient with chronic stroke. www.clinicaltrials.gov (first received 17 November 2015).

Opara 2016 *{published data only}*

Opara J, Szczygiel J. Effects of treadmill training with partial body-weight support on clinical parameters of GAIT early after stroke - preliminary results. *Cerebrovascular Diseases* 2016;**41**:113.

* Szczygiel J, Opara J. Effects of treadmill training with partial body-weight support on biomechanical parameters of gait after stroke. Physiotherapy 2015:eS1151.

Shintani 2005 *{published data only}*

Shintani M, Nagai S, Shimoda S, Wada Y, Sonoda S. High-speed treadmill exercise for stroke hemiplegics. 3rd World Congress of the International Society of Physical and Rehabilitation Medicine - ISPRM; Sao Paulo, Brazil. 2005.

Stephenson 2004 *{published data only}*

Stephenson J, Maitland M, Beckstead J. Body weight support treadmill training compared with PNF training in persons with chronic stroke. *Journal of Neurologic Physical Therapy* 2004;**28**(4):186.

Thompson 2006 *{published data only}*

Thompson M, Medley A. Post stroke locomotor training: does type of practice make a difference?. *Journal of Neurologic Physical Therapy* 2006;**30**(4):209-10.

Venkadesan 2009 *{published data only}*

Venkadesan R, Kumar MKN. A comparative study of conventional gait training versus conventional and treadmill gait training in subacute stroke patients. *Indian Journal of Physiotherapy & Occupational Therapy* 2009;**3**(4):58-62.

Xiao 2014 *{published data only}*

Xiao X, Mao YR, Zhao JL, Li L, Xu GQ, Huang DF. Virtual reality-enhanced body weight-supported treadmill training improved lower limb motor function in patients with cerebral infarction. Chinese Journal of Tissue Engineering Research 2014:1143-8.

Xu 2008 *{published data only}*

Xu W, Zhang L-Y, Fan J-T. The comparison of gait rehabilitation in patients with hemiplegia by walking in water and the pneu-weight walking therapies. *Journal of Rehabilitation Medicine* 2008;**46 Suppl**:73.

Yang 2007 *{published data only}*

Yang A, Su C, Lin K. Effects of long-term exercise intervention on aerobic capacity and functional ability in stroke patients with prior coronary artery disease. *Physiotherapy* 2007;**93 Suppl 1**:s260.

Zielke 2003 *{published data only}*

Zielke DR. The effect of partial body weight supported treadmill training on gait rehabilitation in early acute stroke patients: preliminary data. *Journal of Neurologic Physical Therapy* 2003;**27**(4):177.

References to ongoing studies

ACTRN12609000645257 *{published data only}*

ACTRN12609000645257. Aerobic exercise to improve cardiovascular and neurological health outcomes in the chronic stroke population. www.anzctr.org.au (first received 22 July 2009).

ISRCTN50586966 *{published data only}*

ISRCTN50586966. Improving community walking after a stroke, a new approach. www.controlled-trials.com/ISRCTN50586966 (first received 2 February 2013).

Lennihan 2003 *{unpublished data only}*

Lennihan L, Wootten ME, Wainwright M, Tenteromano L, McMahon D, Cotier J. Treadmill with partial body-weight support versus conventional gait training after stroke. *Archives of Physical Medicine & Rehabilitation* 2003;**84**(9):A5.

Malagoni 2014 *{published data only}*

Malagoni AM, Lamberti N, Zambon C, Felisatti M, Nardini E, Straudi S, et al. Challenging or low exercise intensity to improve mobility and balance for chronic stroke survivors? Preliminary results of a randomized pilot study comparing two supervised 8-week community based. *Acta Clinica Croatica* 2014;**53**:90.

NCT01322607 *{published data only}*

NCT01322607. Task-oriented training for stroke: impact on function mobility. clinicaltrials.gov/show/NCT01322607 (first received 22 March 2011).

NCT01392391 *{published data only}*

NCT01392391. Exercise for sub-acute stroke patients in Jamaica. clinicaltrials.gov/show/NCT01392391 (first received 11 July 2011).

NCT01600391 *{published data only}*

NCT01600391. Visual cues for gait training post-stroke. clinicaltrials.gov/show/NCT01600391 (first received 10 May 2012).

NCT01678547 *{published data only}*

NCT01678547. Robot walking rehabilitation in stroke patients. clinicaltrials.gov/show/NCT01678547 (first received 31 August 2012).

NCT01777113 *{published data only}*

NCT01777113. High intensity interval training in chronic stroke patients. clinicaltrials.gov/show/NCT01777113 (first received 3 January 2013).

NCT02108912 *{published data only}*

NCT02108912. Metabolic costs of walking post stroke. www.clinicaltrials.gov (first received 28 March 2014).

NCT02550015 *{published data only}*

NCT02550015. High intensity interval training after stroke. www.clinicaltrials.gov (first received 8 September 2015).

Additional references

Atkins 2004

Atkins D, Best D, Briss PA, Eccles M, Falck-Ytter Y, Flottorp S, et al. GRADE Working Group. Grading quality of evidence and strength of recommendations. *British Medical Journal* 2004;**328**:1490.

Barbeau 1987

Barbeau H, Rossignol S. Recovery of locomotion after chronic spinalization in the adult cat. *Brain Research* 1987;**412**:84-95.

Bobath 1990

Bobath B. Adult Hemiplegia: Evaluation and Treatment. 2nd Edition. London: Butterworth-Heinemann, 1990.

Brunnstrom 1970

Brunnstrom S. Movement Therapy in Hemiplegia. New York: Harper and Row, 1970.

Carr 1985

Carr JH, Shepherd RB, Nordholm L, Lynne D. Investigation of a new motor assessment scale for stroke patients. *Physical Therapy* 1985;**65**:175-80.

Carr 1998

Carr JH, Shepherd RB. Neurological Rehabilitation: Optimizing Motor Performance. Oxford: Butterworth-Heinemann, 1998.

Charalambous 2013

Charalambous CC, Bonilha HS, Kautz SA, Gregory CM, Bowden MG. Rehabilitating walking speed poststroke with treadmill-based interventions: a systematic review of randomized controlled trials. *Neurorehabilitation and Neural Repair* 2013;**27**(8):709-21.

Collen 1991

Collen FM, Wade DT, Robb GF, Bradshaw CM. The Rivermead Mobility Index: a further development of the Rivermead Motor Assessment. *International Disability Studies* 1991;**13**:50-4.

Collin 1988

Collin C, Wade DR, Davies S, Horne V. The Barthel ADL Index: a reliability study. *International Disability Studies* 1988;**10**:61-3.

De Haan 1993

De Haan R, Aaronson N, Limburg M, Hewer RL, Van Crevel H. Measuring quality of life in stroke. *Stroke* 1993;**24**:320-7.

Enright 1998

Enright PL, Sherrill DL. Reference equations for the six-minute walk in healthy adults. *American Journal of Respiratory and Critical Care Medicine* 1998;**158**:1384-7.

Finch 1985

Finch L, Barbeau H. Hemiplegic gait: new treatment strategies. *Physiotherapy Canada* 1985;**38**:36-41.

Flansbjer 2005

Flansbjer UB, Holmbäck AM, Downham D, Patten C, Lexell J. Reliability of gait performance tests in men and women with hemiparesis after stroke. *Journal of Rehabilitation Medicine* 2005;**37**(2):75-82.

French 2016

French B, Thomas LH, Coupe J, McMahon NE, Connell L, Harrison J, et al. Repetitive task training for improving functional ability after stroke. *Cochrane Database of Systematic Reviews* 2016, Issue 11. [DOI: 10.1002/14651858.CD006073.pub3]

Goff 1969

Goff B. Appropriate afferent stimulation. *Physiotherapy* 1969;**55**:9-17.

GRADEpro GDT [Computer program]

GRADE Working Group, McMaster University. GRADEpro GDT. Version accessed prior to 21 July 2017. Hamilton (ON): GRADE Working Group, McMaster University, 2014.

Guyatt 1984

Guyatt GH, Pugsley SO, Sullivan MJ, Thompson PJ, Berman L, Jones NL, et al. Effect of encouragement on walking test performance. *Thorax* 1984;**39**:818-22.

Hamilton 1994

Hamilton BB, Laughlin JA, Fiedler RC, Granger CV. Interrater reliability of the 7-level functional independence measure (FIM). *Scandinavian Journal of Rehabilitation Medicine* 1994;**26**:115-9.

Hatano 1976

Hatano S. Experience from a multi-centre stroke register: a preliminary report. *Bulletin of the World Health Organization* 1976;**54**:541-53.

Hesse 2003

Hesse S, Werner C. Poststroke motor dysfunction and spasticity: novel pharmacological and physical treatment strategies. *CNS Drugs* 2003;**17**(15):1093-107.

Higgins 2011

Higgins JPT, Green S, editor(s). Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Holden 1984

Holden MK, Gill KM, Magliozzi MR, Nathan J, Peihl-Baker L. Clinical gait assessment in the neurologically impaired: reliability and meaningfulness. *Physical Therapy* 1984;**64**(1):35-40.

Knott 1968

Knott M, Voss DE. Proprioceptive Neuromuscular Facilitation. New York: Harper and Row, 1968.

Langhorne 2002

Langhorne P, Pollock A. What are the components of effective stroke unit care?. *Age & Ageing* 2002;**31**:365-71.

Langhorne 2009

Langhorne P, Coupar F, Pollock A. Motor recovery after stroke: a systematic review. *Lancet Neurology* 2009;**8**(8):741-54.

Manning 2003

Manning CD, Pomeroy VM. Effectiveness of treadmill retraining on gait of hemiparetic stroke patients. *Physiotherapy* 2003;**89**:337-49.

McAuley 2000

McAuley L, Pham B, Tugwell P, Moher D. Does the inclusion of grey literature influence estimates of intervention effectiveness reported in meta-analyses?. *Lancet* 2000;**356**:1228-31.

Mehrholz 2017

Mehrholz J, Thomas S, Pohl M, Werner C, Kugler J, Elsner B. Electromechanical-assisted training for walking after stroke. *Cochrane Database of Systematic Reviews* 2017, Issue 5. [DOI: 10.1002/14651858.CD006185.pub4]

Moore 1993

Moore S, Schurr K, Moseley A, Wales A, Herbert RD. Observation and analysis of hemiplegic gait. II: swing phase. *Australian Journal of Physiotherapy* 1993;**39**:271-7.

Moseley 1993

Moseley A, Wales A, Herbert RD, Schurr K, Moore S. Observation and analysis of hemiplegic gait. I: stance phase. *Australian Journal of Physiotherapy* 1993;**39**:251-6.

Murray 2012

Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;**380**(9859):2197-223.

Pohjasvaara 1997

Pohjasvaara T, Erkinjuntti T, Vataja R, Kaste M. Comparison of stroke features and disability in daily life in patients with ischemic stroke aged 55 to 70 and 71 to 85 years. *Stroke* 1997;**28**(4):729-35.

Polese 2013

Polese JC, Ada L, Dean CM, Nascimento LR, Teixeira-Salmela LF. Treadmill training is effective for ambulatory adults with stroke: a systematic review. *Journal of Physiotherapy* 2013;**59**(2):73-80.

Pollock 2014

Pollock A, Baer G, Campbell P, Choo PL, Forster A, Morris J, et al. Physical rehabilitation approaches for the recovery of function and mobility following stroke. *Cochrane Database of Systematic Reviews* 2014, Issue 4. [DOI: 10.1002/14651858.CD001920.pub3]

RevMan 2012 [Computer program]

Nordic Cochrane Centre, The Cochrane Collaboration. Review Manager 5 (RevMan 5). Version 5.3. Copenhagen: Nordic Cochrane Centre, The Cochrane Collaboration, 2014.

SUTC 2013

Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke. *Cochrane Database of Systematic Reviews* 2013, Issue 9. [DOI: 10.1002/14651858.CD000197.pub3]

Teasell 2003

Teasell RW, Bhogal SK, Foley NC, Speechley MR. Gait retraining post stroke. *Topics in Stroke Rehabilitation* 2003;**10**:34-65.

Van Peppen 2004

Van Peppen RP, Kwakkel G, Wood-Dauphinee S, Hendriks HJ, Van der Wees PJ, Dekker J. The impact of physical therapy on functional outcomes after stroke: what's the evidence?. *Clinical Rehabilitation* 2004;**18**(8):833-62.

Wade 1992

Wade DT. Measurement in Neurological Rehabilitation. Oxford: Oxford University Press, 1992.

References to other published versions of this review

Mehrholz 2014

Mehrholz J, Pohl M, Elsner B. Treadmill training and body weight support for walking after stroke. *Cochrane Database of Systematic Reviews* 2014, Issue 1. [DOI: 10.1002/14651858.CD002840.pub3]

Moseley 2002

Moseley A, Stark A, Cameron I, Pollock A. Treadmill training and body weight support for walking after stroke: a systematic review. 7th International Physiotherapy Congress 25-28 May. Sydney (Australia): Australian Physiotherapy Association, 2002.

Moseley 2003a

Moseley AM, Stark A, Cameron ID, Pollock A. Treadmill training and body weight support for walking after stroke. *Stroke* 2003;**34**(12):3006.

Moseley 2003b

Moseley AM, Stark A, Cameron ID, Pollock A. Treadmill training and body weight support for walking after stroke. *Physiotherapy* 2003;**89**(9):515.

Moseley 2003c

Moseley AM, Stark A, Cameron ID, Pollock A. Treadmill training and body weight support for walking after stroke: a Cochrane systematic review. Stroke Society of Australasia 2003 Annual Scientific Meeting; 2003 17-19 September. Sydney (Australia): Stroke Society of Australasia, 2003.

Moseley 2003d

Moseley AM, Stark A, Cameron ID, Pollock A. Treadmill training and body weight support for walking after stroke: a Cochrane systematic review. Combined Australian Capital Territory Branch and New South Wales Branch of the Australian Physiotherapy Association Mini-Conference; 2003 3 May. Sydney (Australia): Australian Physiotherapy Association, 2003.

* Indicates the major publication for the study

CHARACTERISTICS OF STUDIES

Characteristics of included studies *[ordered by study ID]*

Ada 2003

Methods	Parallel-group design Concealed randomisation of participants by ranking the participants according to independent walking speed at baseline (from fastest to slowest) and then allocating each descending pair of participants by coin toss 14% dropouts at the end of treatment and 10% dropouts at the end of the follow-up phase Outcome assessors were blinded to group allocation
Participants	14 participants in the EXP group and 15 participants in the CTL group Inclusion criteria: less than 5 years post-stroke; first stroke; clinically diagnosed hemiparesis; aged 50 to 85 years; can walk 10 metres independently with a speed less than 1 m/s; discharged from rehabilitation Exclusion criteria: cardiovascular disease that would preclude participation in training (assessed by the participant's medical practitioner); severe cognitive deficits that would preclude participation in training
Interventions	Treated as outpatients for 3 x 30-minute sessions per week for 4 weeks Treadmill training (EXP): participants walk on a treadmill (no body weight support was provided using a harness) and complete some overground walking training (the proportion of overground training is gradually increased)

Ada 2003 *(Continued)*

	Sham training (CTL): home-based exercises based on written instructions with weekly telephone contact to review and update the exercises
Outcomes	Assessed at baseline, after treatment phase and 3-month follow-up: • independent preferred walking speed over 10 m (barefoot and without gait aids) • step length and width • cadence • walking endurance - maximum distance covered in 6 minutes using preferred gait aid • 30-item Stroke Adjusted Sickness Impact Profile
Notes	Obtained unpublished data by interview and correspondence with the trialists.

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomly allocated by coin toss to 1 of 2 groups
Allocation concealment (selection bias)	Low risk	By an investigator independent of recruitment and measurement
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessor blinded

Ada 2010

Methods	Parallel-group design Concealed randomisation Outcome assessor was blinded to group allocation
Participants	Country: Australia 64 participants in the EXP group and 62 participants in the CTL group Inclusion criteria: within 28 days of their first stroke, between 50 and 85 years of age, hemiparesis or hemiplegia clinically diagnosed, and nonambulatory (defined as scoring 0 or 1 on item 5 (walking) of the Motor Assessment Scale for Stroke) Exclusion criteria: clinically evident brain stem signs, severe cognitive and/or language deficits that precluded them from following instructions, unstable cardiac status or any premorbid conditions that precluded them from rehabilitation 126 stroke participants who were unable to walk were recruited and randomly allocated to an experimental or a control group within 4 weeks of stroke
Interventions	Both the EXP and the CTL groups underwent a maximum of 30 minutes per day of walking practice with assistance from 1 therapist for 5 days per week EXP group: involved walking on a treadmill supported in a harness: initial body weight support was set so that the knee was within 15 degrees of extension in mid-stance; initial speed of the treadmill was set so that the therapist had time to assist the leg to swing through while maintaining a reasonable step length CTL group: involved assisted overground walking

Ada 2010 *(Continued)*

Outcomes	The primary outcome was the proportion of participants achieving independent walking within 6 months Independent walking was defined as being able to walk 15 metres overground barefoot without any aids; participants were tested once per week until they achieved independent walking or were discharged from the rehabilitation unit and were tested again at 6 months
Notes	MOBILISE trial

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random permuted (computer-generated) blocks
Allocation concealment (selection bias)	Low risk	A central office was used
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessor was blinded for primary outcome

Ada 2013

Methods	RCT Method of randomisation: computer-generated Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: none Dropouts: 4 (0 in EXP group A, 1 in EXP group B, 3 in CTL group) ITT: yes
Participants	Country: Australia 102 participants (34 in EXP group A, 34 in EXP group B, 34 in CTL group) Ambulatory at study onset Mean age: 63 years; 64 to 70 years (control and EXP groups, respectively) Inclusion criteria: within 5 years of their first stroke, adults capable of providing consent (defined as having a MMSE score of > 23), had been discharged from formal rehabilitation, were community dwelling and walked slowly (defined as being able to walk 10 metres across flat ground in bare feet without any aids taking more than 9 seconds) Exclusion criteria: unstable cardiac status precluding them from participation in a treadmill training program (i.e. permission not granted by their medical practitioner), or had severe cognitive and/or language deficits (aphasia) precluding them from participation in the training sessions (i.e. unable to follow 2-step commands)
Interventions	3 arms: EXP group A undertook 30 minutes of treadmill and overground walking 3 times per week for 4 months EXP group B undertook treadmill training for 2 months CTL group had no intervention
Outcomes	Outcomes were recorded at baseline and after 2, 4, 6 and 12 months • distance in the 6-Minute Walk Test

Ada 2013 *(Continued)*

- walking speed
- step length and cadence
- health status
- community participation
- self efficacy
- falls

Notes	The AMBULATE trial We combined the results of both treadmill groups (EXP group A and EXP group B) as 1 group and compared with the results of the CTL group

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated, independent and concealed randomisation was used to assign each participant in this study
Allocation concealment (selection bias)	Low risk	Independent and concealed allocation was used
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome measures were collected by therapists trained in the measurement procedures who were blind to group allocation

Bonnyaud 2013

Methods	RCT Method of randomisation: not mentioned Blinding of outcome assessors: not stated by the investigator Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: not stated
Participants	Country: France 60 participants (4 groups, division not stated by the author) Walking ability at study onset not mentioned Mean age: 50 years (group GO, GOM; GT, GTM) Inclusion criteria: chronic stroke Exclusion criteria: not stated by the author
Interventions	4 arms: GO: overground without a mass once for 20 min at comfortable speed GOM: overground with a mass once for 20 min at comfortable speed

Bonnyaud 2013 *(Continued)*

	GT: treadmill without a mass once for 20 min at comfortable speed GTM: treadmill with a mass once for 20 min at comfortable speed
Outcomes	Outcomes were recorded at baseline, immediately after the single training session and after a 20 min seated rest • Spatiotemporal parameters: walking speed, cadence and step length • Kinematic parameters: peak hip and knee flexion and peak ankle dorsiflexion • Kinetic parameters: braking and propulsion force peaks and the vertical ground
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method not described
Allocation concealment (selection bias)	Unclear risk	Allocation concealment not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding of assessor was done

Bonnyaud 2013a

Methods	RCT Method of randomisation: not mentioned Blinding of outcome assessors: not stated by the investigator Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: not stated
Participants	Country: France 26 participants (2 groups, division not stated by the author), ambulatory at study onset Mean age: 50 years (group GO and GT) Inclusion criteria: age greater than 18 years, hemiparesis caused by a single hemispheric stroke, ability to walk 20 minutes without a break and without an assistive device Exclusion criteria: any comorbid disability other than stroke, such as any visual impairment or musculoskeletal, cardiovascular, or other disorder that would interfere with the study
Interventions	2 arms: GO: single overground gait-training for 20 min in a corridor at comfortable speed

Bonnyaud 2013a *(Continued)*

	GT: single treadmill gait-training for 20 min at comfortable speed
Outcomes	Outcomes were recorded at baseline, immediately after the end of the session and 20 minutes after the end of the session • spatio temporal parameters: walking speed, cadence, step length, and the percentage of the gait cycle spent in single support phase • kinematic joint parameters: peak hip and knee flexion and extension and peak ankle dorsiflexion and plantar flexion
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	method not described
Allocation concealment (selection bias)	Unclear risk	allocation concealment not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	no blinding of assessor was done

Combs-Miller 2014

Methods	RCT Method of randomisation: drawing sealed envelopes Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 2 (0 in group BWSTT, 2 in group OWT at 3-month follow-up) ITT: yes
Participants	Country: USA 20 participants (10 in group BWSTT, 10 in group OWT) Ambulatory at study onset Mean age: 61 years (56 years BWSTT, 66 years OWT) Inclusion criteria: minimum of six months post ischaemic or haemorrhagic stroke; age between 21 and 80 years; community dwelling; able to walk with or without an assistive device or orthosis at a self-selected gait speed of < 1.0 m/s over 10 m; medically stable with physician release; able to follow two-step verbal instructions Exclusion criteria: currently in physical therapy; health conditions prohibiting exercise or influencing walking ability
Interventions	2 arms: BWSTT group undertook 30 minutes of treadmill training with systematically less body weight support (start at 30%), 5 times per week for 2 weeks OWT group B undertook overground walking training at fast speed, 5 times per week for 2 weeks
Outcomes	Outcomes were recorded at baseline and immediately after, and three months following the intervention • distance in the 6-Minute Walk Test • 10 m walking speed

Combs-Miller 2014 *(Continued)*

- spatio temporal symmetry
- ICF Measure of Participation and ACTivity

Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method for randomisation not clearly described
Allocation concealment (selection bias)	Low risk	Sealed envelopes as method for allocation concealment after baseline assessment
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding of assessor was provided

Da Cunha Filho 2002

Methods	Parallel-group design Participants randomised to groups using a random number table Allocation to groups was not concealed 13% dropouts at the end of the treatment phase Outcome assessors were not blinded to group allocation
Participants	7 participants in the EXP group and 8 participants in the CTL group Inclusion criteria: less than 6 weeks post-stroke; hemiparetic stroke based on clinical examination or MRI, or both; significant gait deficit - speed of no more than 36 m/min or FAC 0 to 2 (that is, needs assistance); sufficient cognition to participate in training (at least 21 on the MMSE); ability to stand and take at least 1 step with or without assistance; informed consent Exclusion criteria: any comorbidity or disability other than hemiparesis that would preclude gait-training; recent myocardial infarction; any uncontrolled health condition for which exercise is contraindicated (e.g. diabetes); severe lower extremity joint disease or rheumatoid arthritis that would interfere with gait-training; obesity (mass more than 110 kg)
Interventions	Treated as inpatients for 5 x 20-minute sessions per week for 2 to 3 weeks BWSTT (EXP): participants walked on a treadmill with up to 30% of their body weight supported using a harness Regular gait-training (CTL): strengthening, functional and mobility activities
Outcomes	Assessed at baseline and after treatment phase: • FAC • FIM - locomotion score • fast walking speed over 5 metres using a gait aid and personal assistance, if required • walking endurance - maximum distance walked in 5 minutes, using parallel bars if necessary • energy expenditure during gait • bike ergometer exercise test
Notes	The rating of dropouts and the allocation concealment classification were changed based on correspondence from the trialist

Risk of bias

Da Cunha Filho 2002 *(Continued)*

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number table
Allocation concealment (selection bias)	High risk	Inadequate (based on correspondence from the investigator)
Blinding of outcome assessment (detection bias) All outcomes	High risk	Not blinded (based on correspondence from the investigator)

Deniz 2011

Methods	RCT Method of randomisation: not described Blinding of outcome assessors: yes Adverse events: not stated Deaths: none Dropouts: none ITT: yes
Participants	Country: Turkey 20 participants (10 in EXP group, 10 in CTL group) Ambulatory at study onset: yes Mean age: 62 years (CTL and EXP groups respectively) Inclusion criteria: ischaemic or haemorrhagic stroke prior 6 weeks to study enrolment, confirmed by MRI, MMSE score $\geq$ 21, supported or independent 1-minute free-standing, significant loss of ambulation (FAC < 3) Exclusion criteria: recurrent stroke interfering with the study, severe contractures of the lower extremity joints, severe cardiac conditions, uncontrolled diabetes mellitus, Parkinson's Disease, current thrombosis in the legs, aphasia, depression and body weight > 110 kg
Interventions	2 arms: CTL group used general physiotherapy, 5 times per week for 4 weeks (300 minutes a week) EXP group received BWSTT, 5 times per week for 4 weeks (300 minutes a week)
Outcomes	Outcomes were recorded at baseline, at the end of the intervention phase and at 3-month follow-up FAC, Rivermead Motor Evaluation Gross (RMD1) and total gross function (RMD2), Berg Balance Scale, Barthel Index, walking capacity (6-Minute Walk Test), walking speed (10 metre walk), cadence rate, ratios of right-left step length, muscle activity (EMG)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not reported
Allocation concealment (selection bias)	Unclear risk	Not reported
Blinding of outcome assessment (detection bias)	Unclear risk	Not reported

Deniz 2011 *(Continued)*

All outcomes

DePaul 2015

Methods	RCT Method of randomisation: permuted block randomisation schedule Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: one or more falls (11 participants in the MLWP and 10 participants in the BWSTT group had 1 fall; 2 in the MLWP and 4 in the BWSTT group reported multiple falls); new stroke: 3 in MLWP, 1 in BWSTT; cardiac event: 2 in the BWSTT group Deaths: 4 (2 in the MLWP, 2 in the BWSTT) Dropouts: 4 (0 in EXP group A, 1 in EXP group B, 3 in CTL group) ITT: yes
Participants	Country: Canada 70 participants (35 in MLWP, 35 in BWSTT) Ambulatory at study onset Mean age: 68 years; (MLWP 66 years, BWSTT 69 years) Inclusion criteria: ≥ 40 years old, living in the community, < 12 months since onset of Ischaemic or haemorrhagic stroke, able to walk 10 m without assistance (gait aid allowed), able to follow a 2-step verbal command, and independent community ambulation prior to stroke Exclusion criteria: cognitive impairment (i.e. MMSE score less than age and education norms); severe visual impairment; lower-extremity amputation; unstable cardiac, medical, or musculoskeletal conditions that would limit treatment participation (determined by physician screening and baseline interview); comfortable gait speed > 1.0 m/s without a gait aid
Interventions	2 arms: 1. MLWP group undertook a Motor Learning Walking Program and practiced various overground walking tasks for 40 minutes, 15 sessions over 5 weeks 2. BWSTT group undertook a Body-Weight-Supported Treadmill Training for 30 minutes, 15 sessions over 5 weeks
Outcomes	Outcomes were recorded at 1 week prior to initiating training, within 1 week following completion of training and 2 months after training • 5-m Walk Test (maximum pace) • 6-Minute Walk Test • the Functional Balance Test (FBT) • Activities-specific Balance Confidence Scale • modified Functional Ambulation Categories • Stroke Impact Scale • Life Space Assessment
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Central randomisation
Allocation concealment (selection bias)	Low risk	Central assignment

DePaul 2015 *(Continued)*

Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded physical therapist

Du 2006

Methods	RCT, parallel-group design Method of randomisation: random number table Allocation concealment: unclear Blinding of outcome assessors: not stated by the authors Adverse events: not stated by the authors Deaths: not stated by the authors Dropouts: not stated by the authors ITT: unclear
Participants	Country: China 128 participants (67 in EXP group, 61 in CTL group) Ambulatory at study onset: 26/61 participants (43%) of the EXP group and 22/67 participants (33%) of the CTL group Mean age: 58 to 56 years (CTL and EXP groups, respectively) Inclusion criteria: ≤ 3 months after stroke, stable stroke, Brunnstrom stage ≥ 2 Exclusion criteria: severe cognitive dysfunction, acute myocardial infarction, unstable angina pectoris, other severe medical conditions of the inner organs
Interventions	2 arms, treated as inpatients and outpatients: CTL group used conventional treatment techniques, 2 times per day for 4 weeks EXP group used BWSTT in addition to the same training as in the CTL group for the same time and frequency
Outcomes	Outcomes were recorded at baseline and after the end of the intervention phase: • walking ability (FAC) • lower limb function (FMA) • activities in daily living (FIM)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number table
Allocation concealment (selection bias)	High risk	To be confirmed
Blinding of outcome assessment (detection bias) All outcomes	High risk	To be confirmed

Duncan 2011

Methods	Parallel-group design

Duncan 2011 *(Continued)*

	Participants were randomised to 3 groups using a stratified randomisation procedure Allocation to groups was concealed 11.5% dropouts at the end of the treatment phase Outcome assessors were not rigorously blinded to group allocation
Participants	Country: USA 408 participants Inclusion criteria: age of 18 years or older, a stroke within 45 days before study entry and the ability to undergo randomisation within 2 months after the stroke, residual paresis in the leg affected by stroke, the ability to walk 3 metres with assistance from no more than 1 person and the ability to follow a 3-step command, the treating physician's approval of participation in the study, a self-selected speed for walking 10 metres of less than 0.8 m per second, and residence in the community by the time of randomisation Exclusion criteria: dependency on assistance in activities of daily living before the stroke, contraindications to exercise, pre-existing neurologic disorders, and inability to travel to the treatment site
Interventions	3 groups: Group 1 (EXP) received training on a treadmill with the use of BWS 2 months after the stroke had occurred (early locomotor training) Group 2 (EXP) received this training 6 months after the stroke had occurred (late locomotor training) Group 3 (CTL) participated in an exercise program at home managed by a physical therapist 2 months after the stroke (home-exercise program) Each intervention included 36 sessions of 90 minutes each for 12 to 16 weeks
Outcomes	The primary outcome was the proportion of participants in each group who had an improvement in functional walking ability 1 year after the stroke Further outcomes were: walking speed; distance walked in 6 minutes; number of steps walked per day; Stroke Impact Scale; FMA legs; Berg Balance Scale; Specific Balance Confidence score
Notes	We combined the results of both EXP groups (Group 1 and Group 2) as 1 group and compared them with the results of the CTL group (Group 3)

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Authors reported that participants were randomly assigned to 1 of 3 groups. Authors described a stratified randomisation procedure in ratios of 140:120:120 stratified by severity. The method of randomisation generation was, however, not described
Allocation concealment (selection bias)	Low risk	The method of allocation concealment was described as: "The study coordinator registers the patient, enters the baseline data into the web based database system, and then obtains group assignment from the data management and analysis center."
Blinding of outcome assessment (detection bias) All outcomes	High risk	Per diem therapists did the assessments

Eich 2004

Methods	Parallel-group design Concealed randomisation of participants to groups by having a person independent of the study asking the participant to draw a sealed opaque envelope from a box (each envelope contained the group allocation and there were 25 EXP and 25 CTL envelopes) 0% dropouts at the end of treatment and 2% dropouts at the end of the follow-up phase Outcome assessors were blinded to group allocation
Participants	25 participants in the EXP group, and 25 participants in the CTL group Inclusion criteria: first time supratentorial stroke; less than 6 weeks post-stroke; aged 50 to 75 years; scores 50 to 80 on 100-point Barthel Index; able to walk a minimum distance of 12 metres with either intermittent help or stand-by assistance; cardiovascular stable; participation in a 12-week comprehensive rehabilitation program; no other neurologic or orthopaedic disease impairing walking; able to understand the purpose and content of the study; written consent
Interventions	Treated as inpatients for 5 x 30-minute sessions per week for 6 weeks TTBWS (EXP): participants walked on a treadmill with up to 15% of their body weight supported using a harness; the slope and speed of the treadmill were adjusted to achieve a training heart rate Regular gait-training (CTL): tone-inhibiting and gait preparatory manoeuvres and walking practice on the floor and stairs based on Bobath (non-task-oriented 'neurophysiological')
Outcomes	Assessed at baseline, after treatment phase, and 3 months later: • fast walking speed over 10 metres with or without a gait aid (supervision and personal assistance was provided, if required) • walking endurance - maximum distance walked in 6 minutes without rest stops, the test was terminated if the participant needed to stop and rest, with or without a gait aid (use of supervision and personal assistance not reported) • walking ability using the Rivermead Motor Assessment scale (13-point scale) • walking quality using an adapted checklist from Los Ranchos Los Amigos Gait Analysis Handbook (41-point scale)
Notes	Method of randomisation and the allocation concealment classification were changed based on correspondence from the trialist

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Using sealed envelopes
Allocation concealment (selection bias)	Low risk	Using sealed envelopes chosen by an independent person
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	The primary outcomes were not blinded; the secondary outcomes of walking ability (Rivermead Motor Assessment scale) and walking quality were blinded

Franceschini 2009

Methods	RCT Method of randomisation: software-generated Blinding of outcome assessors: stated as 'yes' by the trialists Adverse events: not stated Dropouts: 20 (10 in EXP group, 10 in CTL group)

Franceschini 2009 *(Continued)*

	ITT: unclear
Participants	Country: Italy 102 participants (52 in EXP group, 50 in CTL group) Not ambulatory at study onset Mean age: 66 to 71 years (CTL and EXP group, respectively) Inclusion criteria: within 45 days of the onset of hemiparesis caused by right or left ischaemic or haemorrhagic stroke, able to control the sitting position on a rigid plane surface with the legs hanging freely and without the help of the arms for at least 30 seconds; able to control the trunk in the upright position even with the help of the upper extremities gripping a fixed support or other aid (cane, tripod); without lower limb spasticity (Ashworth scale 1), in stable cardiovascular condition with a low, although slightly greater, risk for vigorous exercise than apparently healthy persons (Class B according to the American College of Sports Medicine) Exclusion criteria: significant disability before stroke (modified Rankin Scale 2); significant pre stroke gait disability (Walking Handicap scale 2) and mild gait impairment at time of enrolment (ability to walk without aids for at least 3 metres and to walk for more than 6 metres with the aid of a cane or tripod); participants having done previous treadmill training and/or with a Class C or D exercise risk according to the American College of Sports Medicine criteria or Class III or IV in the New York Heart Association classification system; participants with orthopaedic or other disorders causing a gait limitation before stroke onset Participants who did not complete the treatment (EXP or CTL) within 5 weeks of study inclusion were excluded from the analysis
Interventions	EXP group received conventional rehabilitative treatment plus gait-training with BWS on a treadmill CTL group received conventional treatment with overground gait-training only All participants were treated in 60-minute sessions every weekday for 4 weeks
Outcomes	Outcome measures were: • Motricity Index • Trunk Control test • Barthel Index • FAC • 10-metre and 6-Minute Walk Test • Walking Handicap Scale Assessments were done at baseline, after 20 sessions of treatment, 2 weeks after treatment, and 6 months after stroke
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation scheme was generated by custom-made software that used the Lehmer algorithm
Allocation concealment (selection bias)	Unclear risk	Allocation concealment was not described
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessments were done by therapists and physicians not involved in the treatment of the participant

Gama 2017

Methods	Parallel-group design Concealment of randomisation unclear Outcome assessor was not blinded to group allocation
Participants	Country: Brazil 16 participants in the EXP group and 16 participants in the CTL group Inclusion criteria: chronic hemiparetic gait after an ischaemic or hemorrhagic stroke, > 6 months from the stroke event, absence of cardiac (or medical clearance for participation), orthopaedic, or pulmonary disease or other neurologic impairment that could compromise gait or training, ability to follow 2-step verbal commands, and ability to walk 10 m with or without assistance Exclusion criteria: uncontrolled blood pressure 32 participants after chronic stroke who were able to walk were recruited and randomly allocated to an experimental or a control group
Interventions	Both the EXP and the CTL groups underwent a maximum of 45 minutes per day of walking practice with assistance from 1 therapist for 3 days per week, for 6 weeks (18 sessions) EXP group: involved walking on a treadmill supported in a harness with BWS CTL group: involved assisted overground walking with BWS
Outcomes	Time points: 1 week before training, 1 week after the last training, and at follow-up 6 weeks after last training Outcomes: • 10 m walking velocity • 6 minutes Walking distance • FIM
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-based sequence
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	Described as not done

Gan 2012

Methods	RCT Method of randomisation: not stated Blinding of outcome assessors: unclear Adverse events: not stated Deaths: not stated Dropouts: unclear

Gan 2012 *(Continued)*

	ITT: unclear
Participants	Country: Philippines 205 participants (102 in EXP group, 103 in CTL group) Ambulatory status at study onset: unclear Mean age: unclear Inclusion criteria: unclear Exclusion criteria: unclear
Interventions	Interventions: either to BWS supported overground gait-training or BWS supported treadmill training group BWS was provided by using an overhead harness system with up to 40% of their BWS at the beginning of the training Treadmill speed in the BWS-treadmill group was initially started at 0.5 mph Progression was accomplished by decreasing percentage of BWS or increasing treadmill speed based on gait pattern and endurance
Outcomes	Main outcome measures: study outcome measures included: • balance using the Berg Balance Scale • cadence • 10-metre walking • speed
Notes	Only published as abstract

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method of random sequence generation not described
Allocation concealment (selection bias)	Unclear risk	Method of allocation concealment not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Method of blinding not described

Globas 2011

Methods	RCT Method of randomisation: computer-based Blinding of outcome assessors: not blinded Adverse events: 1 recurrent stroke (EXP group) Dropouts: 2 (2 in EXP group, 0 in CTL group) ITT: stated by the trialists
Participants	Country: Switzerland and Germany 38 participants (20 in EXP group, 18 in CTL group) Ambulatory at study onset Mean age: 69 years (both CTL and EXP groups)

Globas 2011 *(Continued)*

	Inclusion criteria: hemiparetic gait as evaluated by a neurologist with at least 1 clinical sign for paresis, spasticity or circumduction of the affected leg while walking, and the ability to walk on the treadmill at ≥ 0.3 km/hour for 3 minutes with handrail support Exclusion criteria: unstable angina pectoris, heart failure (New York Health Association > II°), haemodynamically significant valvular dysfunction, peripheral arterial occlusive disease, dementia (MMSE < 20), aphasia (unable to follow 2 commands), major depression (CES-D > 16), and other medical conditions precluding participation in aerobic exercise, as well as participants already performing aerobic exercise training for > 20 minutes per day and > 1 day per week
Interventions	3 months (3 times per week) progressive graded, high-intensity aerobic treadmill exercise (TAEX) or conventional care physiotherapy
Outcomes	• peak VO_2 during maximum effort treadmill walking • walking ability measured in 6-minute walks • 10-Metre Walk Test at comfortable (self-selected) and maximum walking speeds • functional leg strength, the 5-Chair-Rise (5CR) • Berg Balance Scale • self rated mobility and activities for daily living function assessed by the Rivermead Mobility Index (RMI) • physical and mental health measured by the Medical Outcomes Study Short-Form 12 (SF-12)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	A computer-based pseudo random number generator and the Moses–Oakford assignment algorithm were used to develop the randomisation schedule
Allocation concealment (selection bias)	Low risk	The procedure was performed by independent study staff at the Department of Biostatistics, University of Ulm, Germany
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding of outcomes was done

Hoyer 2012

Methods	RCT Method of randomisation: computer-based Blinding of outcome assessors: yes Adverse events: not described Dropouts: 0 ITT: not stated by the trialists, probably done because no dropouts were reported
Participants	Country: Norway 60 participants (30 in EXP group, 30 in CTL group) Not ambulatory at study onset Mean age: 52 years (both groups) Inclusion criteria: admission for a primary rehabilitation stay, mainly < 6 months after onset of stroke, use of wheelchair, dependent on assistance for walking with or without walking aids, medically stable, no neurological or orthopaedic contraindications for walking, and sufficient cognitive capacity to understand information and instructions

Hoyer 2012 *(Continued)*

	Exclusion criteria: the participants' need of assistance should not be beyond 1 person for shorter transfer and for taking some steps overground
Interventions	2 arms: Traditional gait-training or treadmill therapy In the traditional gait-training group, intensive gait-training (30 minutes) and functional training (30 minutes) daily for minimum of 10 weeks was conducted In the treadmill therapy, participants walked on a motorised, raised treadmill, secured by a harness combined with a suspension system releasing body weight; this group received 30 sessions of TTBWS, plus conventional gait-training and other functional training for a minimum period of 10 weeks; TTBWS was conducted daily for the first 4 weeks (20 sessions), and then 1 to 2 times a week (10 sessions) for the remaining 6 weeks; on days without TTBWS, conventional gait-training was conducted; each treadmill session lasted for 30 minutes, including necessary pauses, but excluding equipment preparation Time for daily training (5 days a week) was the same in the 2 intervention groups, 30 minutes for walking and 30 minutes for other functional training, including selective training of the trunk and extremities, balance and transfer, customised to individual deficits and needs Additional self training, individually or by the staff, was allowed
Outcomes	Outcomes were recorded at baseline, after 4 to 6 weeks, and after 10 to 12 weeks Primary outcomes: walking ability (FAC and EU-walking scale) Secondary outcomes: walking velocity and steps, walking endurance
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	60 numbers concealed in envelopes were prepared by an external statistician
Allocation concealment (selection bias)	Unclear risk	Not described, probably done because concealed envelopes were used
Blinding of outcome assessment (detection bias) All outcomes	Low risk	A pool of 8 experienced assessors blinded to group allocation were involved in testing

Jaffe 2004

Methods	Parallel-group design Concealed randomisation of participants to groups by using an Excel spreadsheet with group allocation masked using black cells 15% dropouts at the end of the treatment phase and 15% dropouts at the end of the 2-week follow-up Blinding of outcome assessors to group allocation
Participants	11 participants in the EXP group and 12 participants in the CTL group Inclusion criteria: at least 6 months post-stroke; hemiplegia secondary to documented lesion; able to walk independently or with stand-by supervision (with or without a gait aid); asymmetric gait pattern and short step length; 'average' or 'minimal impairment' in all Cognistat test categories; informed consent Exclusion criteria: any medical condition that would prevent participation in a training program; inability to follow instructions

Jaffe 2004 *(Continued)*

Interventions	Treated as outpatients for 6 x 1-hour sessions per week for 2 weeks Virtual reality and treadmill training (EXP): participants practiced stepping over virtual objects while walking on a treadmill, with a harness to prevent falls (each session consisted of 12 trials of stepping over 10 obstacles) Overground training (CTL): participants practiced stepping over real objects while walking overground, with a gait belt for safety (each session consisted of 12 trials of stepping over 10 obstacles; task-oriented)
Outcomes	Assessed at baseline, after treatment phase, and 2 weeks later: • independent preferred walking speed over 6 m with or without a gait aid (supervision, but not personal assistance, was provided) • independent fast walking speed over 6 m with or without a gait aid (supervision, but not personal assistance, was provided) • walking endurance - maximum distance walked in 6 minutes with or without a gait aid (supervision, but not personal assistance, was provided) • spatial and temporal gait variables • ability to clear obstacles
Notes	Rating of concealed allocation, assessor blinding and dropouts, and the allocation concealment classification were changed based on correspondence from the trialist

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method not described
Allocation concealment (selection bias)	Unclear risk	Unclear concealed randomisation
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding of outcome assessors to group allocation

Kang 2012

Methods	RCT Method of randomisation: sealed envelopes Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Dropouts: 2 (2 in EXP groups, 0 in CTL group) ITT: unclear
Participants	Country: Republic of Korea 32 participants (11 in first EXP group, 11 in second EXP group and 10 in CTL group) Ambulatory at study onset Mean age: 56 years (CTL and EXP groups) Inclusion criteria: hemiparetic stroke participants 6 months after diagnosis; participants who could walk on their own for more than 15 minutes; participants without visual disabilities or hemianopia; participants who had a mini-mental state examination score of 21 or higher; Brunnstrum stage > 4 Exclusion criteria: cardiovascular problems; orthopaedic and other neurological diseases except stroke for influencing gait

Kang 2012 *(Continued)*

Interventions	3 arms: 1. wore a head-mounted display to receive speed modulated optic flow during treadmill training for 30 minutes 2. treadmill training 3. regular therapy for the same time, 3 times per week for 4 weeks
Outcomes	Before and after treatment: • Timed Up-and-Go Test • Functional Reach Test • 10-Metre Walk Test • 6-Minute Walk Test
Notes	We combined the results of both EXP groups (arms 1 and 2) as 1 group and compared this group with the results of the CTL group (arm 3)

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Sealed envelopes
Allocation concealment (selection bias)	Low risk	Independent person who picked one of the sealed envelopes before the start of the intervention
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Physical therapists other than the treating physical therapists used in this study for the blinding measurements

Kim 2011

Methods	RCT Method of randomisation: not described Blinding of outcome assessors: no Adverse events: not stated Deaths: none Dropouts: not described ITT: not described
Participants	Country: Republic of Korea 20 participants in the EXP group and 24 participants in the CTL group Inclusion criteria: stroke, able to maintain standing independently for 30 seconds and to walk independently more than 30 metres and able to understand and follow instructions Exclusion criteria: orthopaedic surgery or impairment, Modified Ashworth scale of 2 or more
Interventions	2 arms: 1. EXP group received treadmill training 2. CTL group received lower extremity muscle strength training Both groups received walking therapy for 30 minutes, 3 times a week for 6 weeks
Outcomes	Outcomes were recorded at baseline and after 6 weeks:

Kim 2011 *(Continued)*

- 10-Metre Walk Test
- Timed Up and Go Test
- Berg Balance Scale
- dynamic mean balance in per cent

Notes

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method of randomisation not described
Allocation concealment (selection bias)	Unclear risk	Not described, probably not done
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described, probably not done

Kim 2016

Methods	RCT Method of randomisation: drawing sealed envelopes Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 3 (0 in VRCA group, 0 in CA group , 3 in control) ITT: no
Participants	Country: Korea 30 participants (10 in VRCA group, 10 in CA group, 10 in Control group) Ambulatory at study onset Mean age: 63 years; 64 to 70 years (control and EXP groups, respectively) Inclusion criteria: hemiplegia participants over six months after stroke, gait speed of less than 0.8 m/s, independent ambulation of more than 6 minutes without an assistive device, Mini-Mental State Examination-Korean > 24 points Exclusion criteria: not described
Interventions	3 arms: 1. VRCA group undertook a virtual reality treadmill training-based community ambulation for 30 minutes, 12 sessions, 3 sessions per week 2. CA group undertook a community ambulation training, 30 minutes per session, 3 times per week for 4 weeks 3. CTL group received general exercise program, 10 x 30-minute sessions per week for 4 weeks
Outcomes	Outcomes were recorded at baseline and after the intervention Timed up and go Test, 6-minute walk Test, Activities-specific Balance Confidence Scale spatiotemporal parameters (gait velocity, cadence, paretic step length, paretic stride length)
Notes	

Risk of bias

Kim 2016 *(Continued)*

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method not described (using sealed envelopes)
Allocation concealment (selection bias)	Low risk	Allocated using sealed envelopes
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Blinding not described

Kosak 2000

Methods	Parallel-group design Participants randomised to groups using a random number table Concealed allocation to groups by a person independent of the study 5% dropouts at the end of the treatment phase Blinding of outcome assessors to group allocation
Participants	22 participants in the EXP group and 34 participants in the CTL group Inclusion criteria: no prior stroke; independent with ambulation prior to stroke; no active angina pectoris or orthostatic hypertension; free of other neurologic or orthopaedic disorders that might preclude walking; FIM walking subscore less than or equal to 3 (indicating at least moderate assistance is required for ambulation); hemiparesis with iliopsoas strength less than or equal to 3 out of 5 (indicating significant weakness - full range of movement against gravity only); written informed consent
Interventions	Treated as inpatients for 5 x 45-minute sessions per week for an average of 12.5 (SD 4.7) total treatment sessions Treadmill training with body weight support (EXP): participants walked on a treadmill and were provided with manual guidance for weight shifting, leg advancement, and foot placement Aggressive bracing assisted walking (CTL): participants walked with the assistance of knee-ankle combination bracing and a hemi-bar (non-task-oriented - 'orthopaedic')
Outcomes	Assessed at baseline and after treatment phase: • preferred walking speed over a 2-minute test period (participants allowed to use gait aids and personal assistance, if required) • walking endurance - the distance walked at a preferred speed until the participant indicated fatigue or they exhibited fatigue-related deterioration in gait (participants allowed to use gait aids and personal assistance, if required)
Notes	Rating of concealed allocation and the allocation concealment classification were changed based on correspondence from the trialist

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number table
Allocation concealment (selection bias)	Low risk	Concealed allocation to groups by a person independent of the study

Kosak 2000 *(Continued)*

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Kuys 2011

Methods	RCT Method of randomisation: computer-generated random number program Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: none Dropouts: 2 (2 in EXP group, 0 in CTL group) ITT: ITT used
Participants	Country: Australia 30 participants (15 in EXP group, 15 in CTL group) Ambulatory at study onset Mean age: 72 and 63 years (control and EXP group, respectively) Inclusion criteria: diagnosis of first stroke confirmed by CT scan, were referred for physiotherapy rehabilitation and scored 2 or more on the walking item of the Motor Assessment Scale (i.e. were able to walk with stand-by help), were medically stable, were able to understand simple instructions Exclusion criteria: walking speed was considered normal (> 1.2 m/s), any cardiovascular problems that limited their participation in rehabilitation, or had other neurological or musculoskeletal conditions affecting their walking
Interventions	2 arms: 1. EXP group walked on the treadmill for 30 minutes (excluding rests), 3 times a week for 6 weeks, at an intensity of 40% to 60% heart rate reserve or a Borg Rating of Perceived Exertion of 11 to 14 2. CTL group received usual physiotherapy intervention only
Outcomes	Details of treadmill walking (duration, heart rate reserve, treadmill speed, and distance walked) were recorded for each session: • comfortable and fast walking speed and walking pattern were quantified from a 10-Metre Walk Test as linear kinematics (step length, cadence) using a GAITRite system and angular kinematic parameters using a two-dimensional web cam kinematic software analysis application, and • walking capacity was measured using the 6-Minute Walk Test before and after 6 weeks intervention and after 18 weeks follow-up
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated random number program
Allocation concealment (selection bias)	Low risk	Allocation was concealed from the recruiter through the use of consecutively numbered envelopes
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Measures were taken by assessors blinded to group allocation

Langhammer 2010

Methods	RCT Method of randomisation: by sealed envelopes Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: no Dropouts: 5 (3 in EXP group, 2 in CTL group) ITT: unclear
Participants	Country: Norway 39 participants (21 in EXP group, 18 in CTL group) Not ambulatory at study onset Mean age: 75 and 74 years (control and EXP group, respectively) Inclusion criteria: stroke, neurological impairment and age above 50 years Exclusion criteria: barriers to taking part in a physical rehabilitation program, insufficient language, an unstable cardiac status, neurosurgery, and a premorbid history of orthopaedic problems, or any problems that would prevent a participant from walking
Interventions	2 arm: 1. treadmill training (with handrails to hold on but no body weight or other safety support) 2. walking outdoors for 30 minutes 5 days a week during the inpatient stay until discharge from hospital (length of stay was 16 days in EXP group, and 17 days in CTL group)
Outcomes	Main measures: Six-Minute Walk Test, a 10-Metre Walk Test, and pulse rates at rest and in activity
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Sealed envelopes
Allocation concealment (selection bias)	Low risk	By a person not involved; sealed envelopes
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Assessor blinded

Laufer 2001

Methods	Parallel-group design Alternate assignment of participants to groups, therefore allocation to groups not concealed 14% dropouts at the end of the treatment phase Blinding of outcome assessors to group allocation
Participants	15 participants in the EXP group and 14 participants in the CTL group Inclusion criteria: first supratentorial stroke in anterior brain circulation, as evidenced by CT scanning; no additional neurological or orthopaedic deficiencies impairing ambulation; no cardiac, respiratory, or medical condition that could interfere with the protocol; no severe cognitive or communication impairment; onset of stroke no more than 90 days prior to recruitment; ability to walk on treadmill at a

Laufer 2001 *(Continued)*

	speed of at least 0.2 km/hour for 2 minutes without rest with minimal to moderate assistance; have begun ambulation training
Interventions	Treated as inpatients for 5 sessions of up to 20 minutes per week for 3 weeks (15 treatment sessions) Treadmill training (EXP): participants walked on a treadmill at a comfortable speed with a therapist assisting leg movements; they were permitted use a handrail for external support if required; no body weight support using a harness was provided Overground walking (CTL): participants walked on a floor surface using gait aids, assistance, and rest periods as needed
Outcomes	Assessed at baseline and after treatment phase: • independent fast walking speed over 10 m (participants allowed to use gait aids and supervision, if required) • FAC • standing balance test • gait aids used • temporal characteristics of gait • stride length • calf muscle EMG activity
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	Alternately assigned to groups by order of admittance
Allocation concealment (selection bias)	High risk	Not described, inadequate
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding of outcome assessors to group allocation

Liston 2000

Methods	Cross-over group design Participants randomised to groups by the toss of a coin Allocation concealment not reported 17% dropouts at the end of the first treatment phase Blinding of outcome assessors to group allocation
Participants	10 participants allocated to the EXP then CTL order, and 8 participants allocated to the CTL then EXP order Inclusion criteria: higher level gait disorder; CT scan with large vessel infarct, basal ganglia and white matter lacunes, or extensive leukoaraiosis; discharged from all rehabilitation services; informed consent Exclusion criteria: severe cognitive impairment; significant physical impairments from other causes
Interventions	Treated as inpatients or outpatients for 3 x 1-hour sessions per week for 4 weeks Treadmill training (EXP): participants walked on a treadmill for as long as they felt comfortable; rest breaks were allowed; no body weight support was provided using a harness

Liston 2000 *(Continued)*

	Conventional physiotherapy (CTL): a schedule of 31 interventions in 3 treatment modules: gait ignition or failure, postural alignment and other
Outcomes	Assessed at baseline, at cross-over (4 weeks), after treatment phase (at 8 weeks) and 6 weeks after final treatment: • independent preferred walking speed over 10 m using a gait aid and supervision, if required • walking step length • walking cadence • sit-to-stand test • 1-leg stand • s-test for walking • ADL-oriented assessment of mobility • Nottingham Extended ADL Scale
Notes	The rating of dropouts was changed based on correspondence from the trialist Trial treated as a parallel-group design for this review by using the first treatment phase data only (that is baseline and data before cross-over only)

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	By the toss of a coin
Allocation concealment (selection bias)	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding of outcome assessors to group allocation

Luft 2008

Methods	RCT Method of randomisation: computer-based list Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 42 (20 in EXP group, 22 in CTL group) ITT: no
Participants	Country: USA 113 participants (57 in EXP group, 56 in CTL group) Ambulatory at study onset Mean age: 64 and 63 years (CTL and EXP group, respectively) Inclusion criteria: first clinical ischaemic stroke, older than 45 years of age with chronic hemiparetic gait 6 or more months after completion of conventional subacute rehabilitation Exclusion criteria: heart failure, unstable angina, peripheral arterial occlusive disease, dementia (MMSE ≤ 23 for those with 9th grade education or more and ≤ 17 for those with 8th grade education or less), significant aphasia (unable to follow 2-point commands), untreated major depression (CES-D 16), and other medical conditions precluding participation in aerobic exercise
Interventions	2 arms:

Luft 2008 *(Continued)*

	1. treadmill training sessions (training goal was 3 x 40-minute exercise sessions per week at an aerobic intensity of 60% of heart rate reserve). Duration and intensity started low (10 to 20 minutes, 40% to 50% heart rate reserve) and increased approximately by 5 minutes and 5% heart rate reserve every 2 weeks, as tolerated 2. stretching sessions (performed 13 supervised traditional stretching movements on a raised mat table with a therapist's assistance) over a 6-month period
Outcomes	Assessed at baseline, 3, and 6 months: • maximum walking velocity and VO_2 peak during a treadmill stress test • maximum comfortable walking velocity during a 10-metre walk and a 6-Minute Walk Test)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-based list
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded assessors

MacKay-Lyons 2013

Methods	RCT Method of randomisation: computer-generated, blocked randomisation Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 5 (2 in EXP group, 3 in CTL group) ITT: all analyses were conducted on an ITT basis (that meant carrying the last observation forward for those lost to follow-up)
Participants	Country: Canada 50 participants (24 in EXP group, 26 in CTL group) Ambulatory at study onset Mean age: 59 and 62 years (control and EXP group, respectively) Inclusion criteria: men and women older than 18 years, within 1 month of a first ischaemic stroke confirmed by neuroimaging, inpatients in the stroke rehabilitation unit, and able to walk 5 metres with or without use of ambulatory aids, ankle orthoses or stand-by assistance Exclusion criteria: contraindications to maximal exercise stress testing, musculoskeletal, or cognitive limitations that could preclude participation in the program, or involvement in other pharmacological or physical intervention studies
Interventions	2 arms: 1. body weight-supported treadmill training + usual care 2. usual care

MacKay-Lyons 2013 *(Continued)*

	All individuals participated in 60-minute physiotherapy sessions 5 times weekly as inpatients for 6 weeks and 3 times weekly as outpatients for another 6 weeks for a total of 48 sessions. Substitute sessions for missed appointments were provided
Outcomes	Assessments were done at baseline, post-training, at 6 and 12-month follow-up: • peak oxygen consumption, VO_2 peak • walking ability (6-Minute Walk Test and 10-metre walk) • Berg Balance Scale • motor impairment (Chedoke-McMaster Stages of Recovery, Leg and Foot)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated, blocked randomisation
Allocation concealment (selection bias)	Low risk	A person not involved in the study prepared and safeguarded individual, opaque sealed envelopes containing group and physiotherapist allocation, which were opened after completion of the baseline assessment
Blinding of outcome assessment (detection bias) All outcomes	Low risk	All outcome assessments were conducted by a blinded assessor located off-site

Macko 2005

Methods	Parallel-group design Participants randomised to groups using a computer-generated randomisation scheme that was stratified by walking speed (less than 0.44 m/s and more than or equal to 0.44 m/s) and age (less than 65 years and more than or equal to 65 years) Concealed allocation to groups not reported 26% dropouts at the end of the treatment phase Blinding of outcome assessors to group allocation for gait and balance outcomes (i.e. outcomes 1, 2, 3, and 6)
Participants	32 participants in the EXP group and 29 participants in the CTL group Inclusion criteria: chronic ischaemic stroke (less than 6 months); residual mild to moderate hemiplegic gait deficits; completion of all conventional physiotherapy; aged 45 years or more; (5) independently ambulant with or without a gait aid or stand-by help Exclusion criteria: heart failure, unstable angina, peripheral arterial occlusive disease; aphasia (inability to follow 2-point commands); dementia; untreated major depression; other medical conditions precluding aerobic exercise
Interventions	Treated as outpatients for 3 x 40-minute sessions per week for 6 months Treadmill training (EXP): participants walked on a treadmill to achieve a target aerobic intensity of 60% to 70% heart rate reserve (progressive aerobic training); no body weight support was provided using a harness Conventional physiotherapy (CTL): participants completed a supervised stretching and low-intensity walking program (5 minutes walking on a treadmill at 30% to 40% heart rate reserve without body weight support; task-oriented)
Outcomes	Assessed at baseline and after treatment phase:

Macko 2005 *(Continued)*

- independent self-selected walking speed over 30 feet (participants allowed to use gait aids and supervision, if required)
- independent fastest comfortable walking speed over 30 feet (participants allowed to use gait aids and supervision, if required)
- walking endurance - maximum distance covered in 6 minutes using preferred gait aid
- peak exercise capacity
- rate of oxygen consumption during submaximal effort treadmill walking (economy of gait)
- balance using an instrumented balance assessment system

Notes	Method of randomisation and rating of assessor blinding were changed based on correspondence from the trialist Obtained unpublished data by correspondence with the trialists

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation scheme
Allocation concealment (selection bias)	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding of outcome assessors to group allocation for gait and balance outcomes (i.e. outcomes 1, 2, 3, and 6)

Mao 2015

Methods	RCT Method of randomisation: not described Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 5 (3 BWSTT group, 2 CT group) ITT: unclear
Participants	Country: China 29 participants (15 BWSTT group, 14 CT group) Not ambulatory at study onset Mean age: 60 years Inclusion criteria: first stroke, unilateral hemiparesis for no more than 3 months resulting, abnormal 10m walk time according to age, MMSE score ≥ 27, average modified Ashworth scale score at hip, knee, and ankle ≤ 2 Exclusion criteria: presence of significant medical complications or unstable vital signs
Interventions	2 arms: 1. BWSTT group received body weight-supported treadmill training 20 to 40 minutes 5 times per week for 3 weeks 2. CT group underwent conventional overground walking for same amount of time
Outcomes	Outcomes were recorded at baseline and post training

Mao 2015 *(Continued)*

- kinematic parameters (hip flexion, knee flexion, ankle dorsiflexion, hip extension, knee extension, ankle plantarflexion)
- spatiotemporal parameters (cadence, stride length, stride time, step length, step time, gait speed)
- Fugl-Meyer Lower Extremity Assessment
- Brunel Balance Assessment

Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method not described
Allocation concealment (selection bias)	Unclear risk	Allocation not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding

Mehrberg 2001

Methods	RCT Method of randomisation: not stated Blinding of outcome assessors: not stated Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: unclear
Participants	Country: USA 21 participants (9 in EXP group, 11 in CTL group; according to the authors, 1 participant appears to be missing) Ambulatory status at study onset unclear Mean age: unclear Inclusion criteria: severe hemiparetic participants after stroke (defined as inability to raise and hold affected leg) Exclusion criteria: not stated
Interventions	2 arms: 1. body weight-supported walking (no treadmill) 2. traditional physical therapy 1 hour per day for 3 weeks
Outcomes	Tinetti Balance Scale Functional Ambulation Categories Scandinavian Stroke Scale
Notes	Only published as conference proceeding

Mehrberg 2001 *(Continued)*

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Middleton 2014

Methods	RCT: randomised and matched control group (unclear design) Method of randomisation: drawing concealed envelopes Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 12 (8 in intervention group, 4 in control group) ITT: no
Participants	Country: USA 50 participants (27 intervention group, 23 control group) Not ambulatory at study onset Mean age: 61 years; (range 23 to 86 years in control and intervention groups) Inclusion criteria: age ≥ 18 years, presence of unilateral hemiplegia, ability to follow 3-step commands, sit independently without back or arm support for 5 minutes, stand without support of assistance devices for 5 minutes with no more than minimal assistance, walk 20 feet with occasional moderate help for balance, independently advance assistance devices and bilateral lower extremity during ambulation Exclusion criteria: unable to ambulate 150 feet before stroke, receiving therapy for balance, mobility, and/or gait, significant health risk, serious COPD or oxygen dependence, weight-bearing restrictions, lower extremity amputation, nonhealing lower extremity, severe visual or hearing impairment, significant psychiatric illness, life expectancy < 1 year, severe contracture of lower extremity, deep venous thrombosis or pulmonary embolism within 6 months, uncontrollable diabetes with recent weight loss, diabetic coma or frequent insulin reactions, severe systolic hypertension, history of seizure disorder, neurological conditions other than stroke, severe pain
Interventions	2 arms: 1. Intervention group (BWSTT) undertook gait-training on a treadmill with comfortable speed for 60 minutes and 120 minutes training for balance, strength, coordination and range of motion for 10 consecutive weekdays (total of 30 hours) 2. Experimental group (OGT) received an overground gait-training including training for balance, strength, coordination and range of motion, 3 h for 10 consecutive weekdays (total of 30 hours)
Outcomes	Outcomes were recorded at baseline (2 days before pretest), pretest (1 day before intervention), posttest (1 day after intervention), and follow-up (101 days after completion of intervention) • Stroke Impact Scale • Fugl-Meyer Scale Lower Extremity subscale • Timed Up and Go • Single limb stance

Middleton 2014 *(Continued)*

- Activities-specific Balance Confidence Scale

Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	Unclear randomisation procedure author stated: "randomised and matched"
Allocation concealment (selection bias)	High risk	Unclear allocation author stated: "rolling approach to enrolment"
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded rater

Moore 2010

Methods	RCT with baseline period, followed by cross-over design Method of randomisation: not stated Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 10 (unclear in which period/group) ITT: unclear
Participants	Country: USA 30 participants (probably 15 in EXP group, 15 in CTL group) Ambulatory at study onset Mean age: 57 and 67 years (CTL and EXP group, respectively) Inclusion criteria: ≤ 3 months after stroke, ability to stand or walk 5 metres Exclusion criteria: orthopaedic problems, contractures, NYHA III-IV
Interventions	2 arms: A-B, B-A 20/30 participants with chronic stroke completed a repeated baseline measure with clinical physiotherapy; afterwards participants were randomised in a cross-over trial and received 4 weeks of intensive locomotor training (A) or 4 weeks of no intervention (B) before cross over
Outcomes	Outcome measures included clinical and physiological (metabolic) measures of walking overground and on a treadmill, and measures of daily stepping activity in the home and community, including during clinical physical therapy and subsequent locomotor therapy sessions
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method of randomisation not stated
Allocation concealment (selection bias)	Unclear risk	Method not stated

Moore 2010 *(Continued)*

Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not stated

Nilsson 2001

Methods	Parallel-group design Participants randomised to groups using a random number computer program Concealed allocation to groups using sealed, opaque, and consecutively numbered envelopes 10% dropouts at the end of the treatment phase, 18% dropouts at the 10-month follow-up Blinding of outcome assessors to group allocation
Participants	36 participants in the EXP group and 37 participants in the CTL group Inclusion criteria: first stroke with residual hemiparesis; aged less than 70 years; onset of stroke no more than 8 weeks prior to recruitment; take longer than 14 seconds to walk 10 metres; informed consent Exclusion criteria: participants with heart disease, psychiatric illness or incapable of co-operating; participants with other severe disabilities (e.g. rheumatoid arthritis) that might hinder training; participants participating in other studies
Interventions	Treated as inpatients for 5 x 30-minute sessions per week for the duration of inpatient rehabilitation Treadmill training with body weight support (EXP): participants walked on a treadmill with up to 2 therapists assisting leg movements, they were permitted to use a handrail for external support, if required Overground walking training (CTL): participants practiced walking on a floor surface based on Motor Relearning Program guidelines
Outcomes	Assessed at baseline, after treatment phase (when discharged from inpatient rehabilitation), and 10 months after stroke: • preferred walking speed over 10 metres (participants allowed to use gait aids and personal assistance, if required) • FAC • FIM • FMA • Berg Balance Scale
Notes	Allocation concealment classification was changed based on correspondence from the trialist Data divided into 2 comparisons, see Nilsson 2001a and Nilsson 2001b

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number computer program
Allocation concealment (selection bias)	Low risk	Sealed, opaque, and consecutively numbered envelopes
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinding was done

Nilsson 2001a

Methods	See Nilsson 2001
Participants	See Nilsson 2001
Interventions	See Nilsson 2001
Outcomes	See Nilsson 2001
Notes	For Nilsson 2001a, data from the 54 participants who were dependent walkers at the start of treatment were used (26 EXP and 28 CTL); these walking dependency data were obtained through correspondence with the authors

Nilsson 2001b

Methods	See Nilsson 2001
Participants	See Nilsson 2001
Interventions	See Nilsson 2001
Outcomes	See Nilsson 2001
Notes	For Nilsson 2001b, data from the 19 participants who were independent walkers at the start of treatment were used (10 EXP and 9 CTL); these walking dependency data were obtained through correspondence with the authors

Olawale 2009

Methods	RCT Method of randomisation: not described Blinding of outcome assessors: unclear Adverse events: not reported Deaths: not reported Dropouts: 7 (2 in EXP group, 5 in CTL group) ITT: no
Participants	Country: Nigeria 60 participants (20 in EXP group, 40 in CTL group) Ambulatory at study onset: yes Mean age: 57 years (CTL and EXP group respectively) Inclusion criteria: stroke > 3 months but < 24 months prior to enrolment, ability to walk 10 metres independently without the help of assistive devices, written informed consent Exclusion criteria: not reported
Interventions	3 arms: 1. CTL group 1 used standard physiotherapy, 3 times a week for 12 weeks (3 hours a week) 2. CTL group 2 used standard physiotherapy including overground walking exercises for the same time and frequency 3. EXP group 1 used treadmill training for the same time and frequency

Olawale 2009 *(Continued)*

Outcomes	Outcomes were recorded at baseline, at 4, 8, and after 12 weeks (at the end of the intervention phase) Outcomes: walking speed (10-Metre Walk Test), walking capacity (6-Minute Walk Test)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Park 2013

Methods	RCT Method of randomisation: selecting card from box containing two cards Blinding of outcome assessors: not mentioned Adverse events: not stated Deaths: not stated Dropouts: not reported ITT: not stated
Participants	Country: Korea 40 participants (20 in TGT, 20 in OGT, stratified into n = 10 slow walking and n = 10 fast walking per group) Ambulatory at study onset Mean age: 53 years (TGT group slow walking n = 52 and fast walking n = 53 years and OGT slow walking n = 51 and fast walking n = 55 years) Inclusion criteria: onset of stroke 6 months or more prior to the study; ability to walk for 10 m or more without any aid; ≥ 23 points on the Korean version of the MMSE; no other neurological or orthopaedic lesions; consent to participation Exclusion criteria: not reported
Interventions	2 intervention arms: 1. OGT group undertook overground gait-training for 30 mins twice a day for 5 days 2. TGT group received treadmill gait-training with increased speed for same amount of time
Outcomes	Outcomes were recorded at baseline and after intervention • 10-m walking time • 6-min walking distance • Berg Balance Scale
Notes	

Park 2013 *(Continued)*

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Selecting a card from a box containing two cards
Allocation concealment (selection bias)	Unclear risk	Selecting a card from a box containing two cards (the concealment is unclear)
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding

Park 2015

Methods	RCT Method of randomisation: not mentioned Blinding of outcome assessors: not stated Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: not stated
Participants	Country: Korea 19 participants (9 TRAS group, 10 ORAS group) Mean age: 53 years (51 years TRAS group, 53 years ORAS group) Inclusion criteria: > 6 months and < 2 years after the onset of stroke, walk for 10 minutes or longer on a treadmill, absence of neurotic diseases and abnormal vestibular function, no orthopaedic problems that affect walking, understanding of researchers' instructions, no blood pressure, pulse, or breathing problems after 6 minutes of walking Exclusion criteria: other neurologic conditions that would interfere with walking, receiving other treadmill gait-training
Interventions	2 arms: 1. TRAS group undertook treadmill walking training with rhythmic auditory stimulation 30 minutes, 5 times per week for 3 weeks 2. ORAS group received overground walking training with rhythmic auditory stimulation for the same amount of time
Outcomes	Outcomes were recorded at baseline and after the intervention • spatiotemporal parameters (walking speed, step cycle, step length affected and unaffected lower extremity) • 6-minute walking test • Functional Gait Assessment
Notes	

Risk of bias

Park 2015 *(Continued)*

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	Method of pairing participants with similar physical and balancing abilities
Allocation concealment (selection bias)	High risk	Method of pairing participants with similar physical and balancing abilities
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding was done

Pohl 2002

Methods	Parallel-group design Participants randomised to groups (block randomisation with participants stratified for walking speed) Concealed allocation to groups using sealed, opaque envelopes 13% dropouts at the end of the treatment phase Blinding of outcome assessors to group allocation
Participants	22 participants in the EXP 1 group, 22 participants in the EXP 2 group and 25 participants in the CTL group Inclusion criteria: hemiparesis caused by ischaemic stroke; impaired gait (takes 5 to 60 seconds to walk 10 metres); hemiparesis more than 4 weeks; no or slight spasticity (0 or 1 on the Ashworth scale); able to walk without assistance (FAC of 3 or more); informed consent Exclusion criteria: previous treadmill training; class C or D exercise risk (American College of Sports Medicine Guidelines); cognitive deficits (less than 26 out of 30 on Mini Mental State Examination); movement disorders, orthopaedic or other gait influencing disease
Interventions	Treated as inpatients for 3 x 30-minutes sessions (EXP 1 and EXP 2) or 45-minute sessions (CTL) per week for 4 weeks Speed-dependent treadmill training with body weight support (EXP 1): participants walked on a treadmill without therapist assistance, speed was progressed using an aggressive protocol Limited progressive treadmill training with body weight support (EXP 2): participants walked on a treadmill with therapists assisting the walking cycle, speed was progressed using conservative protocol Conventional gait therapy (CTL): traditional physiotherapy based on neurophysiological techniques
Outcomes	Assessed at baseline and after treatment phase: • independent preferred walking speed over 10 m using gait aids, if required • FAC • cadence • stride length
Notes	The rating of concealed allocation and the allocation concealment classification were changed based on correspondence from the trialist In the update of 2005, the data from this study were divided into 2 comparisons: half of the control group data were used for each comparison. According to Chapter 16.5.4 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011), we combined both treadmill groups, group LTT and group STT together to one treadmill group (to create a single pair-wise comparison) and compared it with the control group We used raw data provided by the trialists

Pohl 2002 *(Continued)*

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessors were blinded

Ribeiro 2013

Methods	Quasi-RCT Method of randomisation: one by one after enrolment in study Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: not stated Deaths: not stated Dropouts: 6 (4 PNF group, 2 TPBWS group) ITT: no
Participants	Country: Brazil 25 participants (n = 12 PFN group and n = 13 TPBWS group) Ambulatory at study onset Mean age: 57 years (range 40 to 70 in both groups) Inclusion criteria: age 40 to 70 years, chronic stroke (≥ 6 months) with hemiparesis, modified Ashworth scale lower extremity 0 to 1 points, Functional Ambulatory Categories 3 to 5, no signs of cardiac alterations, no other neurological or orthopaedic disease interfering with gait, independently walk 10 m without assistive devices or orthotics at paretic leg, follow simple verbal commands Exclusion criteria: age-adjusted heart rate exceeded 75%, fear of falling on treadmill
Interventions	2 arms: 1. PNF group underwent gait-training base on PNF 30 minutes 3 times per week for 4 weeks 2. TPBWS group received treadmill walking training with comfortable speed for same amount of time
Outcomes	Outcomes were recorded at baseline and after the intervention • Stroke Rehabilitation Assessment of Movement • Functional Ambulatory Categories • Functional Independent Measure (motoric parts) • spatiotemporal and kinematic parameters (walking speed, stride length, double-support time, symmetry ratio, max knee and hip flexion, max knee extension, plantarflexion and dorsiflexion)
Notes	

Ribeiro 2013 *(Continued)*

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	Stated as randomised, but participants were according to authors 'selected consecutively, one by one, according to when they enrolled'
Allocation concealment (selection bias)	High risk	'Selected consecutively, one by one, according to when they enrolled'
Blinding of outcome assessment (detection bias) All outcomes	High risk	No blinding

Richards 1993

Methods	Parallel-group design Participants randomised to groups using a stratified block randomisation scheme Concealed allocation to groups not reported 15% dropouts at the end of the treatment phase, number of dropouts not reported at 3 and 6-month follow-up Blinding of outcome assessors to group allocation
Participants	10 participants in the EXP group, 8 participants in the CTL 1 group and 9 participants in the CTL 2 group Nonambulatory at study onset Inclusion criteria: resident within 50 km of Quebec; aged 40 to 80 years; less than 7 days after onset of first stroke; clinically identifiable middle cerebral artery syndrome of thromboembolic origin involving subcortical structures confirmed by CT; under medical supervision of study neurologists; informed consent; middle-band disability according to Garraway (i.e. excluded participants independent in ambulation as well as those who were unconscious) Exclusion criteria: other neurological problems; major medical problems that would incapacitate functional capacity (participants independent in ambulation were excluded)
Interventions	Treated as inpatients for 6 weeks for a mean of 1.74 (SD 0.15) (EXP), 1.79 (SD 0.10) (CTL 1) and 0.72 (SD 0.10) (CTL 2) hours per day Early intensive task-oriented physiotherapy (EXP): treatment started as early as possible after stroke and included treadmill training (no body weight support was provided using a harness), tilt table exercises and resisted exercises using isokinetic equipment Early intensive traditional physiotherapy (CTL 1): treatment started as early as possible after stroke and included traditional physiotherapy based on neurophysiological techniques Delayed non-intensive traditional physiotherapy (CTL 2): treatment started later after stroke and included less intense traditional physiotherapy based on neurophysiological techniques
Outcomes	Assessed at baseline, after treatment phase, and 3 and 6 months later: • walking speed over 4 metres (personal assistance could be used, but speed of test (preferred or fast), supervision and gait aid use not reported) • 15-item Barthel Index • FMA • Berg Balance Scale
Notes	3 and 6-month follow-up data not reported We chose to compare the EXP and CTL 1 groups only for this review because they had the same intensity and starting time of therapy

Richards 1993 *(Continued)*

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Unclear if evaluators were blind to group allocation

Richards 2004

Methods	RCT Method of randomisation: stratified randomisation with random permuted blocks and random block size Blinding of outcome assessors: yes Adverse events: not reported Deaths: not reported Dropouts: 15 (7 in EXP group, 8 in CTL group) ITT: yes
Participants	Country: Canada 63 participants (32 in EXP group, 31 in CTL group) Ambulatory at study onset Mean age: 61 and 63 years (CTL and EXP group, respectively) Inclusion criteria: age between 30 and 89 years, with first or second episode of ischaemic stroke with residual deficit, Barthel Ambulation Subscore $\geq$ 10, gait speed between 0.1 and 0.6 m/s Exclusion criteria: haemorrhagic stroke, inability to understand and follow verbal instructions, major medical problems (diabetes, cancer, aphasia, orthopaedic disorders) interfering with the intervention
Interventions	2 arms: 1. CTL group received physiotherapy in an eclectic approach, 5 times per week for 8 weeks (5 hours per week) 2. EXP group received treadmill training without body weight support, reciprocal stepping and limb loading for the same time and frequency
Outcomes	Outcomes were recorded at baseline, at the end of the intervention phase, and 3 months later Primary outcomes: gait speed by walking 5 metres, 10 metres, or 30 metres at preferred speed Secondary outcomes: lower extremity function (FMA), Timed Up and Go, Functional Independence (Barthel Ambulation Subscore)
Notes	Contamination addressed in the study design by issues of location and personnel

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Stratified randomisation with random permuted blocks and random block size

Richards 2004 *(Continued)*

Allocation concealment (selection bias)	Low risk	After randomisation, treating therapists were informed about assignment
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessor was blinded to group assignment

Scheidtmann 1999

Methods	Cross-over group design Participants randomised to groups (method of randomisation and concealment not stated) 0% dropouts at the end of the first treatment phase Blinding of outcome assessors to group allocation not reported
Participants	15 participants allocated to the EXP then CTL order, and 15 participants allocated to the CTL then EXP order Inclusion criteria: hemiparesis; stroke (infarct or haemorrhage); at least 4 weeks post-stroke; not able to walk; able to stand for 20 seconds Exclusion criteria: cardiovascular problems or infections, with a decrease in general health
Interventions	Treated as inpatients for 5 x 1-hour sessions per week for 3 weeks Treadmill training with body weight support (EXP): participants walked on a treadmill with partial body weight support provided by a harness for 30 minutes plus completed 30 minutes of usual physiotherapy per day Usual physiotherapy (CTL): participants completed 2 x 30-minute sessions of usual physiotherapy per day
Outcomes	Assessed at baseline, at cross-over (3 weeks) and after treatment phase (at 6 weeks): • RMAS • walking speed over 10 m (item 6 of the RMAS) (the speed of test (preferred or fast), personal assistance, supervision and gait aid use were not reported) • a unique gait scale based on clinical assessment
Notes	Trial treated as a parallel-group design for this review by using the first treatment phase data only (that is baseline and data before cross-over only)

Risk of bias

Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Smith 2008

Methods	RCT

Smith 2008 *(Continued)*

	Method of randomisation: modified random assignment, matched-pair CTL group design; stratified regarding (1) motor impairment (measured by FMA) and (2) side of hemiparesis Blinding of outcome assessors: no Adverse events: not reported Deaths: not reported Dropouts: not reported ITT: unclear
Participants	Country: USA 20 participants (10 in EXP group, 10 in CTL group) Ambulatory at study onset: yes Mean age: 56 and 58 years (CTL and EXP group, respectively) Inclusion criteria: informed consent, ischaemic stroke in the distribution of the middle cerebral artery < 3 months, but > 2 years prior to study enrolment, walking slower than prior to the stroke Exclusion criteria: cognitive impairment, inability to ambulate, concomitant pathology interfering with treadmill walking
Interventions	2 arms: 1. CTL group received weekly telephone calls, asking about the quality of the participant's week and encouraging them to record life events in a log 2. EXP group additionally received treadmill training 12 times per month (mean intensity: 1 hour per week)
Outcomes	Outcomes were recorded at baseline, at the end of the intervention phase, and at 6-week follow-up Outcomes: depression (Beck Depression Inventory); Stroke Impact Scale (SIS)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	Outcome assessor was not blinded

Srivastava 2016

Methods	RCT Method of randomisation: table of random numbers Blinding of outcome assessors: stated as 'yes' by the investigator Adverse events: no Deaths: not stated Dropouts: 23 (13 in group 2 and 3, 10 in group 1) ITT: unclear
Participants	Country: India 45 participants (group 1 n = 15, group 2 n = 15, and group 3 n = 15)

Srivastava 2016 *(Continued)*

	Not ambulatory at study onset Mean age: 46 years (24 to 65 years in all groups) Inclusion criteria: first clinical episode of stroke due to an Ischaemic or haemorrhagic supratentorial lesion; right or left hemiparesis, age 16 to 65 years, duration of hemiparesis > 3 months; impaired ability to walk independently or need for one person to help with balance and coordination (Functional Ambulation Category II–IV). Exclusion criteria: recurrent stroke, receptive aphasia with inadequate comprehension to understand and follow the training schedule, MMSE score < 23, score < 12 on the 24-item Hamilton Rating Scale for Depression, movement disorders interfering with training, recent myocardial infarction (< 6 months), ischaemia or angina at rest or during exercise, orthopaedic conditions
Interventions	3 arms: 1. group 1 received overground task-oriented gait-training 2. group 2 received gait-training on a treadmill without bodyweight support (full weight bearing) 3. group 3 received gait-training on a treadmill with partial bodyweight support (40% unweighting of body weight) all groups trained 30 mins per day, 5 day per week for 4 weeks
Outcomes	Outcomes were recorded at baseline, immediately after the intervention, and after 3 months • Scandinavian Stroke Scale • Functional ambulation category • walking speed • walking endurance
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Table of random numbers
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Blinded assessor

Sullivan 2007

Methods	RCT, parallel-group design Method of randomisation: stratified block randomisation (block size not stated) Blinding of outcome assessors: yes Adverse events: 21 cumulative adverse events in 18 participants until follow-up Deaths: none Dropouts: 9 until follow-up (6 in EXP group, 3 in CTL group) ITT: yes, last observation carried forward for primary outcomes
Participants	Country: USA 80 participants (60 in EXP group, 20 in CTL group) Ambulatory at study onset: yes Mean age: 63 and 60 years (CTL and EXP group, respectively)

Sullivan 2007 *(Continued)*

	Inclusion criteria: aged 18 and above, ischaemic or haemorrhagic stroke confirmed by CT, MRI or clinical criteria, 4 to 60 months post-stroke, ambulate at least 10 metres with assistive or orthotic device, FAC 2 or above, walking speed ≤ 1 m/s, informed consent, approval of primary care physician Exclusion criteria: serious medical conditions interfering with the study protocol such as high blood pressure, high resting heart rate, lower limb orthopaedic conditions, recent botulinum toxin injections, recent baclofen delivery, MMSE score < 24, co-interventions aiming at gait-training or lower extremity strengthening, prior enrolment to similar studies, plans to move out of the area of study centres during the next year
Interventions	4 arms: 1. CTL group received combined resistive leg cycling and upper-extremity ergometry, 4 times per week for 6 weeks (4 hours per week) 2. EXP group 1 received combined body weight-supported treadmill training and upper extremity ergometry for the same time and frequency 3. EXP group 2 received combined body weight-supported treadmill training and resistive leg cycling for the same time and frequency 4. EXP group 3 received combined body weight-supported treadmill training and lower extremity progressive-resistive exercise for the same time and frequency
Outcomes	Primary outcome was recorded at baseline, after 12 and 24 treatment sessions, and at 6-month follow-up Secondary outcomes were recorded at baseline, at the end of the intervention phase, and at 6-month follow-up Primary outcome: overground self-selected walking speed Secondary outcomes: fast walking speed, 6-Minute Walk Test, lower extremity FMA, Berg Balance Scale, 16-item Stroke Impact Scale (SIS-16), Medical Outcomes Study Short Form Health Survey (SF-36), lower extremity isometric peak torque
Notes	The 3 experimental groups (using body weight-supported treadmill training) were collapsed together and compared with the CTL group

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random sequence was generated at a central data management centre
Allocation concealment (selection bias)	Low risk	Allocation was performed by a central data management centre
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessors were blinded

Suputtitada 2004

Methods	RCT, parallel-group design Method of randomisation: block randomisation (block size of 4) Blinding of outcome assessors: yes Adverse events: not reported Deaths: not reported Dropouts: not reported ITT: unclear
Participants	Country: Thailand

Suputtitada 2004 *(Continued)*

	48 participants (24 in EXP group, 24 in CTL group) Ambulatory at study onset: yes Mean age: 65 and 61 years (CTL and EXP group, respectively) Inclusion criteria: stroke ≥ 6 months prior to enrolment, able to sit at the edge of the bed independently, independent ambulation with or without gait aids, being able to communicate with therapists, informed consent Exclusion criteria: cardiac risk factors, hyperkinetic movement disorders, using orthoses or prostheses, training less than 2 consecutive weeks
Interventions	2 arms: 1. CTL group received overground walking, 7 times per week for 4 weeks (2.9 hours per week) 2. EXP group received body weight-supported treadmill training for the same time and frequency
Outcomes	Outcomes were recorded at baseline and the end of the intervention phase Measures of timed gait (10-Metre Walk Test); balance ability (Berg Balance Scale)
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessor was blinded

Takami 2010

Methods	RCT Method of randomisation: drawing envelopes containing a lot Blinding of outcome assessors: not described Adverse events: not reported Deaths: not reported Dropouts: 3 (1 in EXP group 1, 2 in EXP group 2, none in the CTL group) ITT: unclear
Participants	Country: Japan 36 participants (12 in EXP group 1, 12 in EXP group 2, 12 in CTL group) Ambulatory at study onset: yes Mean age: 67/71/66 years (CTL and EXP groups 1 and 2, respectively) Inclusion criteria: receive physical therapy, being able to walk 10 metres unassisted, less than 5 weeks post-stroke, FIM-L score ≤ 5, perfect score on the Berg Balance Scale (BBS) or the Rivermead Mobility Index (RMI) Exclusion criteria: time to complete 10-Metre Walk Test < 4 sec, factors interfering with the study like parkinsonism, dementia, severe communication disorders, and orthopaedic conditions
Interventions	3 arms:

Takami 2010 *(Continued)*

	1. CTL group received conventional physiotherapy including overground walking, 6 times per week for 3 weeks (4 hours per week) plus ADL training 5 times per week for 3 weeks (3.3 hours) 2. EXP group 1 received control intervention 6 times per week for 3 weeks (3 hours per week) and additional body weight-supported treadmill training in forward direction 6 times per week for 3 weeks (1 hour per week) 3. EXP group 2 received control intervention 6 times per week for 3 weeks (3 hours per week) and additional body weight-supported treadmill training in backward direction 6 times per week for 3 weeks (1 hour per week)
Outcomes	Primary outcomes were recorded at baseline and once weekly during the 3-week intervention phase Primary outcomes: balance ability (BBS), RMI, 10-metre maximum walking speed, walk ratios during 10 metres of forward walking, and 5 metres of backward walking Secondary outcomes: Motricity Index, Functional Independence Measure Locomotor (FIM-L), modified Borg scale
Notes	Both EXP groups (using body weight-supported treadmill training) were collapsed together and compared with the CTL group

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Low risk	Quote: "[subjects] were randomly allocated [...] using an envelope method."
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not clearly described by the authors, however (quote:) "...a physical therapist measured the required time and number of steps [of measures of timed gait]."

Toledano-Zarhi 2011

Methods	RCT, parallel-group design Method of randomisation: not described Blinding of outcome assessors: not described Adverse events: none Deaths: none Dropouts: 1 in EXP group ITT: yes
Participants	Country: Israel 28 participants (14 in EXP group, 14 in CTL group) Ambulatory at study onset: yes Mean age: 65 years Inclusion criteria: ischaemic stroke within 1 to 3 weeks before the trial, modified Rankin scale $\leq$ 2 Exclusion criteria: systolic blood pressure $\geq$ 200 mm Hg, diastolic blood pressure $\geq$ 110 mm Hg, unstable heart conditions, dementia, age $\geq$ 80 years
Interventions	2 arms: 1. CTL group received a home exercise booklet with included instructions for flexibility and muscle strength exercises

Toledano-Zarhi 2011 *(Continued)*

	2. EXP group received supervised exercise program including treadmill training twice per week for 6 weeks (180 minutes per week exercise training, including 70 to 110 minutes per week treadmill training) additionally to the control intervention
Outcomes	Outcomes were recorded at baseline and at the end of the intervention phase: • gait endurance (6-Minute Walk Test) • dynamic balance (four square step test) • stairs ascending (seconds) • stair descending (seconds) • modified Bruce test: exercise duration (minutes) • modified Bruce test: exercise (metabolic equivalents) • heart rate rest (beats per minute) • heart rate work (beats per minute) • blood pressure rest systolic • blood pressure rest diastolic • blood pressure work systolic • blood pressure work diastolic
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Visintin 1998

Methods	Parallel-group design Participants randomised to groups using a stratified block randomisation scheme Allocation was concealed using sealed and numbered envelopes 21% dropouts at the end of the treatment phase, 48% dropouts at the 3-month follow-up Blinding of outcome assessors to group allocation
Participants	50 participants in the EXP group and 50 participants in the CTL group Inclusion criteria: admitted to the Jewish Rehabilitation Hospital for physical rehabilitation after stroke; abnormal gait; no severe cardiac problems; no comorbid conditions contraindicating treadmill training; not cerebellar, bilateral or brain stem stroke; able to understand simple commands; anticipated length of stay of at least 4 weeks; onset of stroke no more than 6 months prior to recruitment; able to ambulate pre-stroke; first admission during study period; treadmill training time slot available; informed consent
Interventions	Treated as inpatients for 4 x 20-minute session per week for 6 weeks Treadmill training with body weight support (EXP): participants walked on a treadmill with partial body weight support using a harness and the assistance of 1 to 2 therapists

Visintin 1998 *(Continued)*

	Treadmill training only (CTL): participants walked on a treadmill with the assistance of 1 to 2 therapists; no body weight support was provided using a harness
Outcomes	Assessed at baseline, after treatment phase, and 3 months later: • preferred walking speed over 3 m (personal assistance and gait aids could be used) • walking endurance - maximum distance walked up to a maximum of 320 m (personal assistance and gait aids could be used) • Berg Balance Scale • Stroke Rehabilitation Assessment of Movement
Notes	The rating of concealed allocation and the allocation concealment classification were changed based on correspondence from the trialist Data divided into 2 comparisons, see Visintin 1998a and Visintin 1998b

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Drawing lots out of a box
Allocation concealment (selection bias)	Low risk	Allocation was concealed using sealed and numbered envelopes
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessors were blind to group allocation

Visintin 1998a

Methods	See Visintin 1998
Participants	See Visintin 1998
Interventions	See Visintin 1998
Outcomes	See Visintin 1998
Notes	For Visintin 1998a, data from the 59 participants who were dependent walkers at the start of treatment and who did not drop out before the end of the treatment phase were used (33 EXP and 26 CTL); these walking dependency data were obtained through correspondence with the authors

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Drawing lots out of a box
Allocation concealment (selection bias)	Low risk	Allocation was concealed using sealed and numbered envelopes
Blinding of outcome assessment (detection bias)	Low risk	Outcome assessors were blind to group allocation

Visintin 1998a *(Continued)*

All outcomes

Visintin 1998b

Methods	See Visintin 1998
Participants	See Visintin 1998
Interventions	See Visintin 1998
Outcomes	See Visintin 1998
Notes	For Visintin 1998b, data from the 20 participants who were independent walkers at the start of treatment and who did not drop out before the end of the treatment phase were used (10 EXP and 10 CTL); these walking dependency data were obtained through correspondence with the authors

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Drawing lots out of a box
Allocation concealment (selection bias)	Low risk	Allocation was concealed using sealed and numbered envelopes
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessors were blind to group allocation

Weng 2004

Methods	RCT, parallel-group design Method of randomisation: stratified randomisation, generation of random sequence not stated Allocation concealment: not described Blinding of outcome assessors: unclear Adverse events: none Deaths: none Dropouts: 5 (2 in EXP group, 3 in CTL group) ITT: no
Participants	Country: China 50 participants (25 in EXP group, 25 in CTL group) Ambulatory at study onset: yes (FAC ≥ 3) Mean age: 55 years (CTL and EXP group) Inclusion criteria: comply with the Fourth National Stroke diagnostic criteria; stable disease, blood pressure and heart rate control in the normal range, lower extremity Brunnstrom stage ≥ 2, lower ex-

Weng 2004 *(Continued)*

	tremity limb paralysis without severe clonus and joint stiffness (Ashworth scale ≤ 2), participants being able to walk more than 10 metres independently or under supervision and without the help of assistive devices, walking speed ≥ 0.17 m/s Exclusion criteria: history of myocardial infarction, severe ventricular arrhythmias, chronic heart failure; lower extremity total joint replacement or severe arthritis, recurrent stroke, other severe conditions
Interventions	2 arms, treated as inpatients: 1. CTL group received 5 daily sessions of 20 minutes conventional training for 4 weeks 2. EXP group received 5 daily sessions of 20 minutes of body weight-supported treadmill training for 4 weeks
Outcomes	Outcomes were assessed at baseline and at the end of the intervention phase: • lower limb function (lower extremity FMA) • balance ability (Berg Balance Scale) • ADL-performance (FIM) • ambulation (FAC) • maximal walking speed
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Weng 2006

Methods	RCT, parallel-group design Method of randomisation: random number table Allocation concealment: sealed envelopes Blinding of outcome assessors: unclear Adverse events: not stated by the authors Deaths: not stated by the authors Dropouts: unclear ITT: unclear
Participants	Country: China 26 participants (13 in EXP group, 13 in CTL group)

Weng 2006 *(Continued)*

	Ambulatory at study onset: able to walk 10 metres without aids Mean age: 50 and 51 years (CTL and EXP group, respectively) Inclusion criteria: comply with the Fourth National Stroke diagnostic criteria; stable disease, blood pressure and heart rate control in the normal range, lower extremity Brunnstrom stage ≥ 2, lower extremity limb paralysis without severe clonus and joint stiffness (Ashworth scale ≤ 2), participants being able to walk more than 10 m independently and without the help of assistive devices Exclusion criteria: history of myocardial infarction, severe ventricular arrhythmias, chronic heart failure, lower extremity total joint replacement or severe arthritis, recurrent stroke, other severe conditions
Interventions	2 arms, treated as inpatients: 1. CTL group received 5 daily sessions of 60 minutes conventional training for 3 weeks 2. EXP group received 5 daily sessions of 30 minutes conventional training and 30 minutes of additional backward walking with body weight support on a treadmill for 3 weeks
Outcomes	Outcomes were assessed at baseline and at 3 weeks follow-up: • lower extremity FMA • Berg Balance Scale
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number table
Allocation concealment (selection bias)	Low risk	Sealed envelopes
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Werner 2002a

Methods	Cross-over group design Participants randomised to groups (group allocation in envelopes that were drawn by an independent person) 0% dropouts at the end of the first treatment phase Blinding of outcome assessors to group allocation
Participants	15 participants allocated to the EXP then CTL order, and 15 participants allocated to the CTL then EXP order Inclusion criteria: first stroke; supratentorial lesion; 4 to 12 weeks post-stroke; aged less than 75 years; not able to walk (FAC of 2 or less); able to sit unsupported on the edge of a bed; able to stand for at least 10 seconds with help; written informed consent Exclusion criteria: hip and knee extension deficit of more than 20 degrees; passive dorsiflexion of the affected ankle to less than a neutral position; severe impairment of cognition or communication; evidence of cardiac ischaemia, arrhythmia, decompression or heart failure; feeling of 'overexertion' or heart rate exceeding the age-predicted maximum (i.e. 190 beats/minute minus age) during training;

Werner 2002a *(Continued)*

	resting systolic blood pressure exceeding 200 mm Hg at rest or dropping by more than 10 mm Hg with increasing workload
Interventions	Treated as inpatients for 5 x 15 to 20-minute sessions per week for 2 weeks 1. Treadmill training with body weight support (EXP): participants walked on a treadmill with partial body weight support provided by a harness 2. GaitTrainer with body weight support (CTL): participants walked on a GaitTrainer with partial body weight support provided by a harness
Outcomes	This was an A-B-A (or B-A-B) design, so participants were assessed at baseline, at first cross-over (2 weeks), at second cross-over (4 weeks) and after treatment phase (6 weeks): • FAC • fast walking speed over 10 m with personal assistance and gait aids, if required • RMAS • ankle spasticity (modified Ashworth Scale)
Notes	The number of dropouts was changed based on correspondence with the trialists Trial treated as a parallel-group design for this review by using the first treatment phase data only (that is, baseline and data from the first phase of the cross-over trial only)

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Lots with sealed opaque envelopes that were drawn by an independent person
Allocation concealment (selection bias)	Low risk	Sealed opaque envelopes that were drawn by an independent person
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Unclear if outcome assessors were blinded to group assignment

Yang 2010

Methods	RCT in parallel-group design Method of randomisation: drawing lots out of an envelope Blinding of outcome assessors: yes Adverse events: not reported Deaths: none Dropouts: none ITT: yes
Participants	Country: Taiwan 18 participants (10 in EXP group, 8 in CTL group) Mean age: 55 and 57 years (CTL and EXP group, respectively) Inclusion criteria: diagnosis with unilateral hemiparesis due to stroke with < 6 months or > 12 months post-stroke, being able to follow simple verbal commands Exclusion criteria: unstable medical conditions, history of other diseases interfering with the study, history of seizure, severe cardiovascular conditions/pacemaker
Interventions	4 arms:

Yang 2010 *(Continued)*

1. EXP group 1 with participants < 6 months post-stroke received body weight-supported treadmill training for 30 minutes followed by 20 minutes general exercise program, 3 times per week for 4 weeks (150 minutes per week)
2. CTL group 1 with participants < 6 months post-stroke received the general exercise program for 50 minutes, 3 times per week for 4 weeks (150 minutes per week)
3. EXP group 2 with participants > 12 months post-stroke received body weight-supported treadmill training for 30 minutes followed by 20 minutes general exercise program, 3 times per week for 4 weeks (150 minutes per week)
4. CTL group 2 with participants > 12 months post-stroke received the general exercise program for 50 minutes, 3 times per week for 4 weeks (150 minutes per week)

Outcomes	Outcomes were recorded at baseline and at the end of the intervention phase Primary outcomes: motor threshold and cortical map size Secondary outcomes: lower limb function (FMA)
Notes	We combined the experimental groups and compared them with the combined controlled groups

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Low risk	Drawing lots out of an envelope
Blinding of outcome assessment (detection bias) All outcomes	Low risk	Outcome assessor was blinded

Yen 2008

Methods	RCT Method of randomisation: described that an independent person selected 1 of the sealed envelopes containing allocation Adverse events: not stated Deaths: none Dropouts: none ITT: yes
Participants	Country: Taiwan 14 participants (7 in EXP group, 7 in CTL group) Ambulatory at study onset: able to walk 10 metres Mean age: 56 and 57 years (CTL and EXP group, respectively) Inclusion criteria: unilateral stroke with unilateral hemiparesis, ≥ 6 months post-stroke, ability to walk at least 10 metres independently with or without assistance, no severe cognitive impairment, stable medical condition Exclusion criteria: history of seizure, any orthopaedic or neurological conditions interfering with the study, cardiac problems/pacemaker, metallic implants in the head, walk with normal gait pattern, inability to walk pre-stroke
Interventions	2 arms: 1. CTL group used general physiotherapy, 2 to 5 times per week for 4 weeks (100 to 250 minutes per week)

Yen 2008 *(Continued)*

	2. EXP group, additionally to the control intervention, received 12 additional sessions of BWSTT, 3 times per week for 4 weeks (90 minutes per week)
Outcomes	Outcomes were recorded at baseline and at the end of the intervention phase • balance performance (Berg Balance Scale) • gait performance (GAITRite) at maximal walking speed • corticomotor activity
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Independent person selected one of the sealed envelopes containing a lot
Allocation concealment (selection bias)	Low risk	Independent person selected one of the sealed envelopes containing a lot
Blinding of outcome assessment (detection bias) All outcomes	High risk	Outcome assessor was not blinded

Zhang 2008

Methods	RCT, parallel-group design Method of randomisation: no details described by the authors Allocation concealment: no details described by the authors Blinding of outcome assessors: no blinding Adverse events: not stated by the authors Deaths: not stated by the authors Dropouts: not clearly stated by the authors ITT: unclear
Participants	Country: China 39 participants (19 in EXP group, 20 in CTL group) Ambulatory at study onset: not stated by the authors Mean age: 63 years (CTL and EXP group, respectively) Inclusion criteria: ischaemic or haemorrhagic stroke confirmed by CT or MRI; aged 52 to 70 years; stable vital signs, conscious, being able to adhere to instructions; lower limb dysfunction Brunnstrom stage 2; blood pressure > 140/90 mm Hg, no myocardial infarction or angina pectoris Exclusion criteria: not stated by the authors
Interventions	2 arms, treated as inpatients: 1. CTL group used conventional physical therapy (treatment dosage not stated)

Zhang 2008 *(Continued)*

	2. EXP group received conventional physical therapy and additional BWSTT for 5 x 30-minute sessions, 8 weeks, started with 40% weight-bearing relief and 0.2 km/hour and was gradually decreased or increased, respectively
Outcomes	Outcomes were assessed at baseline and at the end of the intervention phase: • ankle dorsiflexion (tibialis anterior muscle) EMG activity • ankle plantarflexion (gastrocnemius muscle) EMG activity • co-contraction ratio of agonist and antagonist
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not described
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	Unclear risk	Not described

Zhu 2004

Methods	RCT, parallel-group design Method of randomisation: random number table Allocation concealment: unclear Blinding of outcome assessors: no Adverse events: not reported by the authors Dropouts: none, all participants completed the study ITT: yes
Participants	Country: China 20 participants (10 in EXP group, 10 in CTL group) Ambulatory at study onset: not stated by the authors Mean age: 58 and 57 years (CTL and EXP group, respectively) Inclusion criteria: aged 30 to 80 years; ischaemic or haemorrhagic stroke; confirmed by CT or MRI; not able to walk (FAC of 2 or less); being able to stand up without help; MMSE ≥ 21 points Exclusion criteria: other conditions than stroke affecting ambulation, such as history of spinal cord injury or amputation; myocardial infarction; severe heart failure; poor kidney function; uncontrolled diabetes mellitus; activated rheumatic diseases; MMSE < 21 points; body weight ≥ 110 kg
Interventions	2 arms, treated as inpatients:

Zhu 2004 *(Continued)*

1. treadmill training with body weight support (EXP): participants walked on the Pneu-weight system 5 sessions per week for 4 weeks (duration of sessions not stated), therapy (duration, body weight support) was tailored to the participants individual capabilities
2. traditional gait-training (CTL): conventional functional gait-training 5 sessions per week for 4 weeks (duration of sessions not stated)

Outcomes	Assessed at baseline and at the end of the intervention phase: • walking ability (FAC) • balance ability (BBS) The following outcomes were measured by footprint analysis: • ipsilateral stepping length • contralateral stepping length • contralateral stride • ipsilateral stride • contralateral step angle • ipsilateral step angle • cadence • step width • walking speed
Notes	

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number table
Allocation concealment (selection bias)	Unclear risk	Not described
Blinding of outcome assessment (detection bias) All outcomes	High risk	Outcome assessor was not blinded

ADL: activities of daily living
BBS: Berg Balance Scale
BWS: body weight support
BWSTT: body weight-supported treadmill training
CT: computed tomography
CTL: control
EMG: electromyographic activity
EXP: experimental
FAC: Functional Ambulation Category
FIM: Functional Independence Measure
FMA: Fugl-Meyer Assessment
GT: Gait trainer
ICF: international classification of functioning
ITT: intention-to-treat
km/hr: kilometres per hour
LTT: limited progressive treadmill training
max: maximum
m/min: metre per minute
m/s: metre per second

MMSE: Mini Mental State Examination
MRI: magnetic resonance imaging
NYHA: New York Heart Association
PNF: Proprioceptive Neuromuscular Facilitation
RCT: randomised controlled trial
RMAS: Rivermead Motor Assessment Scale
RMI: Rivermead Mobility Index
SD: standard deviation
SF-12: short form 12-item (for measuring health-related quality of life)
SF-36: short form 36-item (for measuring health-related quality of life)
SIS: stroke impact scale
STT: speed-dependent treadmill training
TBC: to be confirmed
TTBWS: treadmill training with body weight support
VO2: volume of oxygen consumption

Characteristics of excluded studies *[ordered by study ID]*

Study	Reason for exclusion
Aschbacher 2006	Irrelevant intervention: electromechanical device training
Bayat 2005	Described only a single-session application of treadmill training
Bleckert 2006	Both groups received treadmill training and differed only in the speed of the treadmill
Blennerhassett 2004	Irrelevant intervention: circuit class training
Borsje 2003	Correspondence with the author revealed that the trial was abandoned
Brissot 2006	Investigated electromechanically assisted gait-training
Caldwell 2000	Correspondence with the author revealed that the trial was abandoned after the recruitment of only 5 participants (each allocated to 1 of 3 treatment groups)
Daly 2004	Both groups received treadmill training; the parameter that was experimentally manipulated was electrical stimulation
Daly 2011	Both groups received treadmill training and differed only by means of functional electrical stimulation
Dean 2000	Irrelevant intervention: circuit class training
DEGAS 2007	Irrelevant intervention: electromechanical device training
Dias 2007	Irrelevant intervention: electromechanical device training
Druzbicki 2016	Control group also received treadmill training
English 2007	Irrelevant intervention: circuit class training
Fisher 2008	Irrelevant intervention: electromechanical device training
Forrester 2004	Evaluated a single treatment session, not a full course of treatment
Freivogel 2009	Mixed population of participants with traumatic brain injury, spinal cord injury, and stroke; only 2 out of 16 included participants had a stroke

Study	Reason for exclusion
Globokar 2005	Irrelevant intervention: electromechanical device training
Hidler 2009	Irrelevant intervention: electromechanical device training
Hornby 2008	Irrelevant intervention: robotic device training
Husemann 2007	Irrelevant intervention: electromechanical device training
Jang 2005	Irrelevant intervention: electromechanical device training
Jeong 2008	Irrelevant intervention: electromechanical device training
Khanna 2003	Correspondence with the author revealed that the trial was abandoned before the commencement of recruitment
Kim 2001	Irrelevant intervention: electromechanical device training
Kim 2008	Irrelevant intervention: electromechanical device training
Kovrazhkina 2009	Irrelevant intervention: electromechanical device training
Kwakkel 1999	Correspondence with the author revealed that less than 20% of participants in the EXP group participated in treadmill training (i.e. only 6 out of 31 participants)
Langhammer 2000	Correspondence with the author revealed that treadmill training (with or without body weight support) was not used in either group
Langhammer 2007	Fewer than 20% of participants in the EXP group received treadmill training
Lau 2010	Both groups received treadmill training which differed only by speed
Lee 2013	Both groups received treadmill training
Lindquist 2011	Quasi-experimental study, without randomisation
Macko 2006	Both groups received treadmill training which differed only by duration and speed
Mayr 2007	EXP group used an electromechanical device on a treadmill
Mayr 2008	Irrelevant intervention: electromechanical device training
McCain 2008	Not an RCT
Michael 2011	Not a randomised controlled trial
NCT00018421	Investigated cardiovascular fitness and energy expenditure
NCT00108030	compared BWS + TT with BWS + TT plus power training
NCT00284115	Investigated electromechanical-assisted gait-training
NCT00612300	Irrelevant intervention: electromechanical device training
NCT00891514	Investigated aerobic exercise and inflammation

Study	Reason for exclusion
NCT01146587	Suspended
NCT01337960	Evaluated ankle robot
NCT01674790	Assessed cognition
NCT02043574	Measured energy expenditure
NCT02680496	Measured energy consumption and cardiorespiratory load during walking
NCT02735148	Investigated robot-assisted device (Lokomat)
NCT02798237	Not yet recruiting
NCT02956096	Not yet recruiting
NCT03006731	Not yet recruiting
NCT03056287	Not yet recruiting
Pang 2010	Not an RCT
Park 2012	Both groups received treadmill training and differed only in the setting (underwater treadmill versus overground treadmill)
Peurala 2005	Did not use treadmill training
Peurala 2009	Irrelevant intervention: electromechanical device training
Ploughman 2008	Evaluation of a single treatment session
Rimmer 2000	Correspondence with the author revealed that only one-third of participants in the EXP group participated in treadmill training
Salbach 2004	Irrelevant intervention: circuit class training
Saltuari 2004	Irrelevant intervention: electromechanical device training
Schwartz 2009	Irrelevant intervention: electromechanical device training
Shafshak 2012	All groups received treadmill training with partial body weight support: the parameter that was experimentally manipulated was upper limb swinging
Sullivan 2002	All groups received treadmill training with partial body weight support; the parameter that was experimentally manipulated was treadmill speed
Tong 2006	Irrelevant intervention: electromechanical device training
Trueblood 2001	A non-random process was used to allocate participants to groups in Part II and Part III Participants chose which treatment they would receive
Tsai 2004	All groups received treadmill training (without partial body weight support); the parameters that were experimentally manipulated were walking direction and treadmill slope

Study	Reason for exclusion
Tsang 2012	Irrelevant outcome: echocardiography
Werner 2002b	Both groups received treadmill training with body weight support; the parameter that was experimentally manipulated was 'conventional' physiotherapy gait-training
Westlake 2009	Used robot-assisted training (Lokomat)
Yagura 2006	Both groups received treadmill training with body weight support; the parameter that was experimentally manipulated was therapeutic facilitation
Yang 2008	Both groups received treadmill training and differed only by the EXP group receiving virtual reality as well

EXP: experimental
RCT: randomised controlled trial

Characteristics of studies awaiting assessment *[ordered by study ID]*

Baer 2009

Methods	Method: multicentre RCT Method of randomisation: stratified randomisation based on side of lesion and initial FAC score Blinding of outcome assessors: not described Adverse events: not stated Deaths: not stated Dropouts: 8 during intervention phase ITT: unclear
Participants	Country: UK 77 people with subacute stroke within 3 months of stroke onset Ambulatory at study onset: not described Inclusion criteria: stroke as defined by WHO; age over 18; medically stable; 1 minute standing balance (with or without support), ability to understand and follow verbal instructions
Interventions	2 arms: 1. CTL group received "normal gait re-education" for 8 weeks, at least 3 times per week 2. EXP group received gait re-education by treadmill training for 8 weeks, at least 3 times per week
Outcomes	Outcomes were recorded at baseline and after 8 weeks of therapy: Measures of timed gait (10-Metre Walk Test) • Motor Assessment Scale • FAC • gait capacity (6-Minute Walk Test) • ADL (Barthel Index) • modified Rivermead Mobility Index • Timed Up and Go • Stroke Impact Scale
Notes	Characteristics derived from conference abstract

Bartloff 2009

Methods	Unclear
Participants	Unclear
Interventions	Unclear
Outcomes	Unclear
Notes	

Mokrusch 2004

Methods	Method: not described Method of randomisation: not described Dropouts: not stated Blinding of outcome assessors: unclear ITT: unclear
Participants	Country: Germany 7 participants Inclusion criteria: not described Exclusion criteria: not described
Interventions	Treated for 4 weeks Treadmill training (EXP): participants received treadmill training in combination with functional electrical stimulation Conventional physiotherapy (CTL): based on the Bobath/neurodevelopmental approach
Outcomes	Assessed at baseline and after treatment: • gait speed • physiological cost index
Notes	Characteristics derived from conference abstract

Muller 2004

Methods	Method: not described Method of randomisation: not described Drop outs:not stated Blinding of outcome assessors: unclear ITT: unclear
Participants	Country: Germany 50 participants in the EXP group, 44 participants in the CTL group Ambulatory at study onset: unclear Inclusion criteria: not clearly described, quote "stroke and spinal patients"

Muller 2004 *(Continued)*

	Exclusion criteria: not described
Interventions	Treatment duration: unknown Treadmill training (EXP): participants received treadmill training for 45 minutes per session Electromechanical assisted gait-training (CTL): using the Lokomat on a treadmill for 45 minutes per session
Outcomes	Assessed at baseline and after treatment : 1. effective training time 2. gait endurance (distance walked in therapy sessions)
Notes	Characteristics derived from conference abstract

NCT01789853

Methods	Method: RCT, parallel assignment Method of randomisation: not described Blinding of outcome assessors: yes ITT: unclear
Participants	Country: USA 56 people with chronic stroke Ambulatory at study onset: yes Inclusion criteria: subacute (< 6 months) stroke; 18 to 75 years old; history of unilateral, supratentorial, ischaemic or haemorrhagic stroke; being able to walk 10 metres without physical assistance; gait speed less than or equal to 0.8 m/s; medical clearance Exclusion criteria: significant cardiorespiratory or metabolic disease that may limit exercise participation; weight limit > 113 kg; history of previous orthopaedic or neurological conditions which may impair walking; MMSE < 23 Exclusion for transcranial magnetic stimulation (TMS): pacemaker, metal implants in the head region, history of epilepsy or seizures, skull fractures or skull deficits, concussion within the last 6 months, unexplained recurring headaches, medications that lower seizure threshold, pregnancy Exclusion for the MRI: aneurysm clip or coil, metal or wire implants, heart valve prosthesis
Interventions	2 arms: 1. CTL group will receive conventional physiotherapy for 8 weeks, at least 3 times per week 2. EXP group will receive locomotor training including treadmill training, overground walking training, overground walking training and stair climbing for 8 weeks, 5 times per week (200 minutes per week)
Outcomes	Primary outcomes will be assessed at baseline, at the end of the intervention phase at 8 weeks, and at 3-month follow-up: • gait speed (change in 10-Metre Walk Test) Secondary outcomes will be assessed at baseline, at the end of the intervention phase at 8 weeks, and at 2-month follow-up: • change in 6-Minute Walk Test

NCT01789853 *(Continued)*

	• change in Berg Balance Scale
Notes	

NCT02619110

Methods	Method: not described Method of randomisation: not described Dropouts: not stated Blinding of outcome assessors: not blinded ITT: unclear
Participants	People after chronic stroke Inclusion criteria: • this experiment recruited participants with chronic stroke more than 6 months, whose level of Brunnstrom stage was beyond IV and who were able to walk more than 11 metres with or without assistive devices Exclusion criteria: unclear
Interventions	• EXP: backward walking treadmill training participants received 30 minutes backward walking treadmill training per week for 4 weeks • CTL: conventional physical therapy participants received 30 minutes traditional physical therapy 3 times per week for 4 weeks
Outcomes	After 4 weeks: • Berg Balance Scale • Timed 10-Meter Walk Test • 6-minute walk test • Up and Go test (TUG)
Notes	

Opara 2016

Methods	Method of randomisation: not described Dropouts: not stated Blinding of outcome assessors: not blinded ITT: unclear
Participants	60 people after stroke, including those with hemiparesis Inclusion criteria: up to 3 months after stroke with limited gait function Exclusion criteria: unclear
Interventions	• EXP: treadmill training with BWS (consisted of 30 participants who applied exercises using a device that enables partial body weight support - UnWeighing System) 4 weeks, 5 days a week, for 30 minutes per day, body weight support was 30%, speed of the treadmill was between 1 and 4.2 km/h, an average of 1.5 km/h • CTL: walking training was carried out using traditional methods

Opara 2016 *(Continued)*

Outcomes	Time points of assessment: after 4 weeks of training • 10-Meter Walk Test • Functional Index "Repty" • Timed Up and Go Test, P • Functional Ambulatory Category
Notes	Information provided in part by the primary investigator

Shintani 2005

Methods	Unclear
Participants	Unclear
Interventions	Unclear
Outcomes	Unclear
Notes	

Stephenson 2004

Methods	Unclear
Participants	Unclear
Interventions	Unclear
Outcomes	Unclear
Notes	

Thompson 2006

Methods	RCT Method of randomisation: not described Blinding of outcome assessors: not described Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: not stated
Participants	Country: USA 22 participants Ambulatory at study onset: not stated Mean age: 58 years Inclusion criteria: not stated Exclusion criteria: not stated
Interventions	3 arms:

Thompson 2006 *(Continued)*

	1. CTL: overground walking at a self-selected speed, 2 times per week for 4 weeks (40 minutes per week) 2. EXP 1: body weight-supported treadmill training at self-selected speed, 2 times per week for 4 weeks (40 minutes per week) 3. EXP 2: body weight-supported treadmill training at fast speed, 2 times per week for 4 weeks (40 minutes per week)
Outcomes	Outcomes were recorded at baseline, post intervention, and after 1-month and 6-month follow-up: • lower limb function (Fugl-Meyer Assessment) • ADL performance (Barthel-Index) • gait endurance (6-Minute Walk Test) • measures of timed gait (10-Metre Walk Test)
Notes	Abstract only

Venkadesan 2009

Methods	Method: not described Method of randomisation: not described Dropouts: not stated Blinding of outcome assessors: unclear ITT: unclear
Participants	Country: India 10 participants in the EXP group, 10 participants in the CTL group Ambulatory at study onset: yes Inclusion criteria: not described Exclusion criteria: not described
Interventions	Treatment duration: unknown Treadmill training (EXP): participants received treadmill training and conventional gait-training Conventional gait-training (CTL): participants received conventional gait-training alone
Outcomes	Time points of assessments unknown: • cadence • stride length
Notes	Characteristics derived from abstract

Xiao 2014

Methods	Unclear
Participants	Unclear
Interventions	Unclear

Xiao 2014 *(Continued)*

Outcomes	Unclear
Notes	

Xu 2008

Methods	Method: not described Method of randomisation: not described Dropouts: not stated Blinding of outcome assessors: unclear ITT: unclear
Participants	Country: China 36 participants in the EXP group, 40 participants in the CTL group Ambulatory at study onset: not described Inclusion criteria: not described Exclusion criteria: not described
Interventions	Treatment duration: unknown Pneu-weight walking training (EXP): participants received Pneu-weight walking training Underwater gait-training (CTL): participants received underwater gait-training
Outcomes	Time points of assessments unknown: • improvement of walking ability (outcome measure: unknown)
Notes	Characteristics derived from conference abstract

Yang 2007

Methods	Method: RCT, parallel group design Method of randomisation: not described Blinding of outcome assessors: not described Adverse events: not stated Deaths: not stated Dropouts: not stated ITT: unclear
Participants	Country: Taiwan 13 participants in the EXP group and 13 in the CTL group Ambulatory at study onset: not described Inclusion criteria: hemiparetic gait disturbances and coronary artery disease Exclusion criteria: not stated
Interventions	2 arms: 1. EXP group received aerobic treadmill exercise for 6 months

Yang 2007 *(Continued)*

	2. CTL group received no intervention
Outcomes	Outcomes were recorded at baseline and after 4 weeks of therapy: • aerobic capacity (symptom limited exercise test) • ADL (Barthel Index)
Notes	Characteristics derived from conference abstract

Zielke 2003

Methods	Unclear
Participants	5 participants will be recruited for the EXP group and 5 participants for the CTL group Inclusion criteria: admitted to inpatient stroke unit between 2 and 30 days following stroke; single infarct stroke confirmed by MRI or CT scan; aged 50 to 75 years; no orthopaedic or additional neurologic conditions that impair ambulation (independent walker, with or without a gait aid, before the stroke); no history of previous stroke (based on medical chart review); no cardiac, respiratory, or other medical condition that might interfere with the treatment protocol; able to follow instructions (no significant cognitive or communication deficits); scores at least 1 out of 5 on manual muscle testing of the hip flexors
Interventions	Treated for 3 sessions per week for 2 weeks Treadmill training (EXP): participants will walk on a treadmill with partial body weight support using a harness Overground walking training (CTL): participants will complete overground walking training
Outcomes	Assessed at baseline, and after the treatment (2 weeks): 1. Berg Balance Scale 2. walking speed 3. gait portion of the Tinetti assessment 4. FIM - gait score
Notes	

ADL: activities of daily living
BWS: body weight-support
BWSTT: body weight-supported treadmill training
CTL: control
EMG: electromyographic activity
EXP: experimental
FAC: Functional Ambulation Categories
FIM: Functional Independence Measure
ITT: intention-to-treat
MMSE: Mini Mental State Examination
MRI: magnetic resonance imaging
RCT: randomised controlled trial
TMS: transcranial magnetic stimulation
TUG: timed up-and-go-test
WHO: World Health Organization

Characteristics of ongoing studies *[ordered by study ID]*

ACTRN12609000645257

Trial name or title	Aerobic exercise to improve cardiovascular and neurological health outcomes in the chronic stroke population
Methods	Method: RCT, parallel group design Method of randomisation: secure web-based computer generation, stratified according to age (< 65 versus > 65) and mobility (the 6-Minute Walk Test, < 160 metres versus > 160 metres) Blinding of outcome assessors: yes ITT: unclear
Participants	Country: Australia Target sample size: 150 participants Ambulatory at study onset: not described Inclusion criteria: aged between 45 and 80 years, diagnosis of first or recurrent stroke, haemorrhage or infarct at least 6 months prior to study entry Exclusion criteria: unable to participate in an exercise program due to medical conditions such as heart failure, unstable angina, dementia, and receptive aphasia, participants on beta-blockers, participants already participating in a supervised aerobic exercise program, participants who have epilepsy, metallic implants in the skull or cardiac pacemakers (exclusion from the transcranial magnetic stimulation)
Interventions	2 arms: • EXP group received aerobic treadmill exercise 3 times per week for 12 weeks • CTL group received usual care 3 times per week for 12 weeks
Outcomes	Outcomes were recorded at baseline, at the end of the 12-week intervention period, and at 6 months follow-up: Primary outcome: peak oxygen uptake (VO_2 peak) Secondary outcomes: • Timed Up and Go Test, 6-Minute Walk Test, gait velocity, Sit-to-Stand Test • cognitive function (the Stroop Test, verbal fluency, trail making tests A and B, Rey Auditory Verbal learning test, digit span backwards and forwards, spatial span test, a clock drawing task test, inspection time, Paced Auditory Serial Addition Test) • cerebral blood flow and vessel reactivity (Doppler sonography) • quality of life (Assessment of Quality of Life tool) • cost-effectiveness and cost utility using the AQoL to calculate quality adjusted life years (QALYs) • response to stimulation of the motor cortex to induce plasticity (repetitive transcranial magnetic stimulation)
Starting date	August 2009
Contact information	Dr Michelle McDonnell School of Nursing and Midwifery GPO Box 2471 Adelaide SA 5001, Australia Email: michelle.mcdonnell@unisa.edu.au
Notes	

ISRCTN50586966

Trial name or title	Improving community walking after a stroke, a new approach
Methods	Method: pilot RCT Method of randomisation: not described Blinding of outcome assessors: not described ITT: unclear
Participants	Country: UK 50 people with chronic stroke Ambulatory at study onset: yes Inclusion criteria: more than 6 months after first ischaemic stroke; reduced gait capacity (6-Minute Walk Test); being able to perform a simple reciprocal bilateral foot tapping task and to walk safely on a treadmill; informed consent Exclusion criteria: high risk of psychosis; severe aphasia; history of previous stroke; other known contraindication to safe participation; contraindication to MRI
Interventions	2 arms: • CTL group will receive 24 sessions of 45 minutes of aerobic walking training • EXP group will receive implicit dual task-training during body weight-supported treadmill training for 24 sessions of 45 minutes
Outcomes	Outcomes will be assessed at 0, 10, and 20 weeks: • community mobility • health and well-being • changes in walking performance (temporal spatial parameters, walking endurance) • adherence to training • brain activation changes
Starting date	February 2013
Contact information	Prof Helen Dawes Oxford Brookes University, Movement Science Group, School of Life Email: hdawes@brookes.ac.uk
Notes	16 January 2017: The following changes have been made to the record: • the scientific title, secondary outcome measures, publication and dissemination plan, IPD sharing plan, ORCID ID, plain English summary and trial participating centres have been added • the overall trial dates have been updated from 30/01/2013 to 30/12/2014 to 01/08/2011 to 31/08/2016 • information about the randomisation process and length of training sessions have been added to the interventions section

Lennihan 2003

Trial name or title	Treadmill with partial body weight support versus conventional gait-training after stroke
Methods	Unclear

Lennihan 2003 *(Continued)*

Participants	42 participants will be recruited for the EXP group and 41 participants for the CTL group Inclusion criteria: within 30 days of first stroke; hemiparesis; dependent on supervision or physical assistance from at least 1 person to walk; not ataxic
Interventions	Treated as inpatients for 12 x 30-minute per day sessions over 3 weeks Treadmill training (EXP): participants will walk on a treadmill with partial body weight support using a harness Conventional physiotherapy (CTL): participants will participate in conventional physiotherapy (standing, walking, sit-to-stand, and standing and walking with activity)
Outcomes	Assessed 90 days after stroke: • walking speed • walking endurance - maximum distance covered in 6 minutes using preferred gait aid • FIM • National Institute of Health Stroke Scale score • Fugl-Meyer Assessment leg motor score • Tinetti score
Starting date	Unknown
Contact information	Unknown
Notes	Characteristics derived from conference abstract

Malagoni 2014

Trial name or title	Challenging or low-intensity to improve mobility
Methods	Unclear
Participants	8 adults with chronic stroke > 6 months (M = 7, age = 71 ± 11 years, hemiplegia n = 6) were randomised
Interventions	EXP: 'treadmill walking strength training' intervention, based on moderate-intensity treadmill walking (4-weeks) and lower limbs muscle strength training with gym machines (4-weeks) CTL: 'ground walking-power training' program combining interval low-intensity ground walking (4-weeks) and lower limbs muscle power training performed with wearable weights (4-weeks) Each intervention was performed 3 times per week for 8 weeks, for a total of 24 sessions
Outcomes	The 6-minute walking distance, up-and-go time, 10 m time, 5-sit-to-stand-to-sit time, balance score (Berg Balance Scale) maximal strength and peak power of quadriceps and biceps femoris (Kg and Watts, respectively determined by force-velocity curve by the linear encoder MuscleLab, Roma, Italy), were measured before and after 8 weeks
Starting date	
Contact information	
Notes	All participants completed the program. Both treatments showed improvements, although not significant, for all parameters. CTL showed significant improvement compared to EXP for 5STS (P = 0.021), 10MWT (P = 0.043), maximal strength of biceps femoris for all legs (P = 0.037), peak power for quadriceps (P = 0.021) and for all legs (P = 0.006)

NCT01322607

Trial name or title	Task-oriented training for stroke: impact on function mobility
Methods	Method: RCT, parallel assignment Method of randomisation: not described Blinding of outcome assessors: no ITT: no
Participants	Country: USA 60 people with stroke Ambulatory at study onset: yes Inclusion criteria: stroke > 6 months prior with residual hemiparetic gait in women or men aged 40 to 85 years, completion of all regular post-stroke physical therapy, adequate language and neurocognitive function to participate in testing and training and to give adequate informed consent, able to rise from a chair unaided and able to walk 10 metres without human assistance Exclusion criteria: regular structured aerobic exercise (> 2 x week), raised alcohol consumption by self-report, clinical history of severe heart conditions, peripheral arterial obstructive disease with claudication, major orthopaedic, chronic pain or non-stroke neuromuscular disorders restricting exercise, pulmonary or renal failure, poorly controlled hypertension (> 190/110) measured on at least 2 separate occasions, recent hospitalisation for severe disease or surgery, severe or global receptive aphasia which confounds reliable testing and training, untreated major depression as documented by a CES-D score of > 16 and confirmed by clinical interview, pregnancy
Interventions	2 arms: • CTL group will receive a low-intensity lifestyle intervention (group exercises incorporating balance, co-ordination and strength) (time frame not described) • EXP group will receive a high-intensity treadmill walking program (time frame not described)
Outcomes	Outcomes will be assessed at baseline and at 3 months: Primary outcomes: economy of gait Secondary outcomes: • muscular strength • muscular endurance • balance
Starting date	July 2011
Contact information	Alyssa D Stookey, PhD MS Email: alyssa.stookey@va.gov
Notes	

NCT01392391

Trial name or title	Exercise for subacute stroke patients in Jamaica
Methods	Method: RCT, parallel assignment

NCT01392391 *(Continued)*

	Method of randomisation: stratified based on glucose tolerance (normal versus abnormal) and gait deficit severity Blinding of outcome assessors: no ITT: unclear
Participants	Country: Jamaica 150 people with chronic stroke Ambulatory at study onset: unclear Inclusion criteria: ischaemic stroke within 2 months; BMI of 18 to 40 kg/m^2; being able to walk 3 minutes with handrails, assistive device or stand-by aid Exclusion criteria: actively exercising for > 30 minutes per day for 5 days per week; increased alcohol consumption; active abuse of other illegal and illicit drugs; history of severe cardiac conditions; history of (1) peripheral arterial disease with vascular claudication making exercise challenging, (2) orthopaedic or chronic pain condition(s) restricting exercise, (3) pulmonary or renal failure, (4) active cancer, (5) untreated poorly controlled hypertension measured on at least 2 occasions (greater than 160/100), (6) HIV-AIDS or other known inflammatory responses, (7) sickle cell anaemia, (8) medications: heparin, warfarin, Lovenox or oral steroids, (9) currently pregnant, (10) history of type 1 diabetes or insulin dependent type 2 diabetes, (11) poorly controlled type 2 diabetes (HbA1C > 10), (12) dementia (MMSE score < 23 or < 17 if education level at or below 8th grade) and clinical confirmation by clinical evaluation, (13) severe receptive or global aphasia that confounds testing and/or training, operationally defined as unable to follow 2-point commands, (14) hemiparetic gait from a prior stroke preceding the index stroke defining eligibility (more than one stroke), (15) neurologic disorder restricting exercise such as Parkinson's or myopathy, (16) untreated major depression (CES-D > 16 or clinical confirmation), (17) muscular disorder(s) restricting exercise; muscle biopsy exclusion criteria: (1) anticoagulation therapy with heparin, warfarin or Lovenox (antiplatelet therapy is permitted), (2) bleeding disorder
Interventions	2 arms: • CTL group will receive best medical stroke care 'Get with the guidelines' for Jamaica for 6 months • EXP group, in addition to the control intervention, will receive treadmill training for 6 months, 3 times per week (18 to 90 minutes per week) and group dynamic balance exercise
Outcomes	Outcomes will be assessed at baseline and at the end of the intervention phase at 6 months: Primary outcomes: • thigh and abdominal muscle and fat • whole body protein and skeletal muscle synthesis and breakdown (serial blood sampling and pre-/post-muscle biopsies in the fasted and fed state) • muscle myosin heavy chain isoform proportions (muscle biopsy) • leg strength (1 repetitive maximum strength for leg extension, quadriceps, and hamstring muscles) • fitness (VO_2 peak testing with open circuit spirometry) • glucose tolerance (2-hour oral glucose tolerance test with serial blood sampling every 30 minutes for glucose and insulin) Secondary outcomes: • muscle TNF alpha (muscle biopsy) • mobility and balance (National Institutes of Health Stroke Scale, modified Ashworth, timed walks, Short Physical Performance Battery, Berg Balance Scale)
Starting date	July 2011
Contact information	Richard F Macko, MD

NCT01392391 *(Continued)*

	Email: rmacko@grecc.umaryland.edu
Notes	

NCT01600391

Trial name or title	Visual cues for gait training post stroke
Methods	Method: RCT, parallel assignment Method of randomisation: not described Blinding of outcome assessors: yes ITT: unclear
Participants	Country: Australia Target sample size: 60 people with stroke Ambulatory at study onset: yes Inclusion criteria: diagnosis of stroke; being able to walk 10 metres with or without assistance; residual paresis in the lower limb (Fugl-Meyer lower limb score less than 34), informed written consent Exclusion criteria: gait speed more than 0.8 m/s; participants with a premorbid (retrospective) modified Rankin Scale score of greater than 3; gait deficits attributable to nonstroke pathology; visual impairments preventing use of visual cue training (as assessed by Apple Cancellation test), concurrent progressive neurologic disorder, acute coronary syndrome, severe heart failure, confirmed or suspected lower-limb fracture preventing mobilisation, those requiring palliative care, inability to follow a 3-step command (as assessed by Modified MMSE)
Interventions	3 arms: • Active comparator: usual care group will receive task-specific overground walking rehabilitation for 8 weeks, 2 times per week (120 minutes per week) • EXP: overground visual cue training group will receive overground walking rehabilitation with visual cues for 8 weeks, 2 times per week (120 minutes per week) • EXP: treadmill visual cue training group will receive treadmill training with visual cues for 8 weeks, 2 times per week (120 minutes per week)
Outcomes	Outcomes will be assessed at baseline, at the end of the intervention phase, and at 3-month follow-up: Primary outcome: participant enrolment, recruitment, and retention Secondary outcomes: • 180 degree turn (time taken (s) and number of steps (#) to complete a 180 degree turn) • gait adaptability (the number of times participants fail to hit stepping targets when these are presented unpredictably in timing and location will be used to indicate the ability to adapt the straight gait pattern according to environmental demands) • Timed Up and Go (TUG) test (7 metres) • Fugl-Meyer Lower Limb Motor Assessment • Berg Balance Scale • Falls Efficacy Scale • health-related quality of life (SF-12) • FAC

NCT01600391 *(Continued)*

	• gait speed (10-metre walk)
Starting date	May 2012
Contact information	Trudy A Pelton, MRes Email: t.a.pelton@bham.ac.uk Kristen Hollands, PhD Email: k.hollands@salford.ac.uk
Notes	

NCT01678547

Trial name or title	Robot walking rehabilitation in stroke patients
Methods	RCT with 3 arms
Participants	Inclusion criteria: between the ages of 18 and 95 years, able to walk 25 feet unassisted or with assistance, first acute event of cerebrovascular stroke, unilateral paresis, ability to understand and follow simple instructions, ability to walk without assistance before stroke, endurance sufficient to stand at least 20 minutes unassisted per participant report Exclusion criteria: unable to understand instructions required by the study (Informed Consent Test of Comprehension), medical or neurological comorbidities that might contribute to significant gait dysfunction, uncontrolled hypertension > 190/110 mm Hg, significant symptoms of orthostasis when standing up, circulatory problems, history of vascular claudication or significant (+ 3) pitting oedema, lower extremity injuries or joint problems (hip or leg) that limit range of motion or function or cause pain with movement, bilateral impairment, severe sensory deficits in the paretic upper limb, cognitive impairment or behavioural dysfunction that would influence the ability to comprehend or participate in the study, women who are pregnant or lactating or both
Interventions	EXP group: robot G-EO: each participant will be asked to perform 15 sessions (3 to 5 days a week for 4 up to 5 weeks) consisting of a treatment cycle using the GE-O system device, according to individually tailored exercise scheduling CTL group: treadmill training: each participant will be asked to perform 15 sessions (3 to 5 days a week for 4 up to 5 weeks) consisting of a treatment cycle using the treadmill system device, according to individually tailored exercise scheduling CTL group: ground treatment: Ground Control Group: each participant will be asked to perform 15 sessions (3 to 5 days a week for 4 up to 5 weeks) of traditional lower limb physiotherapy This review will only analyse 1 control group compared to the other
Outcomes	Outcomes will be assessed at baseline and at 6 months follow-up: Primary outcomes: 6-Minute Walk Test Secondary outcomes: • Fugl-Meyer Assessment (lower limb) • Borg scale • gait parameters with EMG • FAC • Walk Handicap Scale
Starting date	September 2012
Contact information	Contact: Patrizio Sale, MD

NCT01678547 *(Continued)*

	Email: patrizio.sale@gmail.com Contact: Marco Franceschini, MD Email: marco.franceschini@sanraffaele.it
Notes	Estimated enrolment: 90 Estimated study completion date: September 2015 Estimated primary completion date: August 2014 (final data collection date for primary outcome measure)

NCT01777113

Trial name or title	High-intensity interval training in chronic stroke patients
Methods	Method: RCT Method of randomisation: not described Blinding of outcome assessors: yes ITT: unclear
Participants	Country: Italy Target sample size: 100 people with stroke Ambulatory at study onset: not described Inclusion criteria: diagnosis of ischaemic or haemorrhagic stroke, confirmed by MRI or CT at least 6 months before the onset of the study; ability to walk in the treadmill at > 0.3 km/hour for 3 minutes with handrail support; be able to give informed consent and be motivated to participate in 3-month intensive physical fitness training Exclusion criteria: MMSE < 20; unstable angina pectoris; unstable cardiac conditions; complex ventricular arrhythmia; resting systolic blood pressure > 200 mm Hg, resting diastolic blood pressure > 100 mm Hg; aphasia (unable to follow 2 commands); other medical conditions precluding participation in aerobic exercise
Interventions	3 arms: • EXP group 1 will receive high-intensity treadmill training for 12 weeks • EXP group 2 will receive high-intensity strength training for 12 weeks • Active comparator group will receive conventional training consisting of group mobility, balance, and stretching exercises for 12 weeks
Outcomes	Primary outcome will be assessed at baseline and at the end of the intervention phase at 12 weeks: 6-Minute Walk Test Secondary outcomes: • 10-Metre Walk Test • Timed Up and Go Test • gait analysis • strength (isokinetic dynamometer) • arterial - venous oxygen difference (Near Infrared Spectroscopy) • cardiac output (Portapres) • Oxygen Uptake Efficiency Slope • Specific Balance Confidence Scale • SF-36 Health Survey Questionnaire • Stroke Impact scale

NCT01777113 *(Continued)*

	• peak oxygen consumption (VO_2 peak) • walking energy cost
Starting date	March 2013
Contact information	Nicola Smania Email: nicola.smania@univr.it
Notes	

NCT02108912

Trial name or title	Metabolic costs of walking post stroke
Methods	Method: pilot RCT Method of randomisation: not described Blinding of outcome assessors: not described ITT: unclear
Participants	Country: USA 30 people with chronic stroke Ambulatory at study onset: unclear Inclusion criteria: • confirmed diagnosis of recent cerebrovascular accident (less than 6 weeks post-strokeat the time of admission to inpatient rehabilitation) • able to give informed consent independently or have family member or other authorized surrogate available to give consent • first time stroke OR complete gait recovery from prior stroke • sufficient support at home to participate in home-based fitness training program • transportation to University of Texas Southwestern Medical Center Gait Disorders Clinic for therapy and testing • ability to follow one-part commands Exclusion criteria: • not ambulatory before onset of stroke (at time of admission to inpatient rehabilitation) • bilateral stroke • presence of severe cardiac problems (heart failure (New York Heart Association > Class 2), unstable or exercise-induced angina) • other comorbidities which could affect gait-training (i.e. amputation, spinal cord injury, traumatic brain injury, etc.) • recent myocardial infarct (within 4 weeks of date of inpatient rehabilitation admission) • any uncontrolled health condition for which exercise is contraindicated • severe lower extremity joint disease/pathology that would interfere with gait-training • participants - with body mass index (BMI) greater than 40 • significant cognitive impairment (less than 2 on the FIM cognitive subscale) • age greater than 80 years or less than 18 years • able to complete 5 or more full heel raises with the affected ankle in standing with the knee extended with no more than one or two fingers on support surface for balance
Interventions	2 arms:

NCT02108912 *(Continued)*

	• CTL: traditional outpatient therapy • EXP: treadmill outpatient therapy
Outcomes	Primary outcome: • maximum exercise tolerance Secondary outcome will be assessed at enrolment, week 9, week 17, and week 25: • 6-Minute Walk Test
Starting date	March 2014
Contact information	Karen J McCain, DPT University of Texas Southwestern Medical Center
Notes	

NCT02550015

Trial name or title	High intensity interval training after stroke
Methods	Method: RCT Method of randomisation: not described Blinding of outcome assessors: not described ITT: unclear
Participants	Country: Norway 30 people with chronic stroke Ambulatory at study onset: unclear Inclusion criteria: • approved informed consent • independent walking > 2 minutes • first episode of stroke (Ischaemic or hemorrhagic) • minimum 3 months post-stroke • living in the community and able to travel to assessment and training site • approval to participate from the study's responsible medical doctor • modified Rankin Scale 0 to 3 Exclusion criteria: • impaired cognitive function to give valid informed consent to participate • instability of cardiac conditions (i.e. serious rhythm disorder, valve malfunction) • other conditions where test of maximal oxygen uptake is contraindicated • poorly controlled hypertension (> 180/100), measured at rest • > 5 years post-stroke • subarachnoid haemorrhage • participating in other ongoing intervention study • other serious illness influencing testing of cardiorespiratory fitness and function at 1 year follow-up

NCT02550015 *(Continued)*

Interventions	2 arms: • EXP: high intensity interval training (uphill treadmill walking 4 x 4 min at 90 to 95% of peak heart rate) 3 times weekly for 8 weeks • CTL: standard care Standard clinical follow-up care, including general information about importance of physical activity as part of a healthy lifestyle
Outcomes	Primary outcome • maximal oxygen uptake Secondary outcome will be assessed at 8 weeks and 12 months after inclusion • 6-Minute Walk Test • walking speed
Starting date	September 2015
Contact information	Torunn Askim, PhD Norwegian University of Science and Technology Contact: Tor Ivar Gjellesvik tor.i.gjellesvik@ntnu.no
Notes	

10MWT: 10 meters walk test
5STS: five time sit-to-stand
6MWD: six minute walk distance
BMI: body mass index
BWS: body weight support
BWSTT: body weight-supported treadmill training
CES-D: Center for Epidemiologic Studies Depression Scale
CT: computed tomography
CTL: control
CVA: cerebrovascular accident
DPT: academic title (Doctor of Physical therapy)
EMG: Electromyography
EXP: experimental
FAC: Functional Ambulation Categories
FIM: Functional Independence Measure
G-EO: the G-EO System is a brand name of a robotic gait trainer
IPD: individual patient data
ITT: intention-to-treat
M: male
MMSE: Mini Mental State Examination
MRI: magnetic resonance imaging
ORCID: Open Researcher and Contributor identification
QALY: quality adjusted life years
RCT: randomised controlled trial
SF-36: short form 36
TNF: tumor necrosis factor
TUG: timed-up-and-go-test
VO_2: volume of oxygen consumption

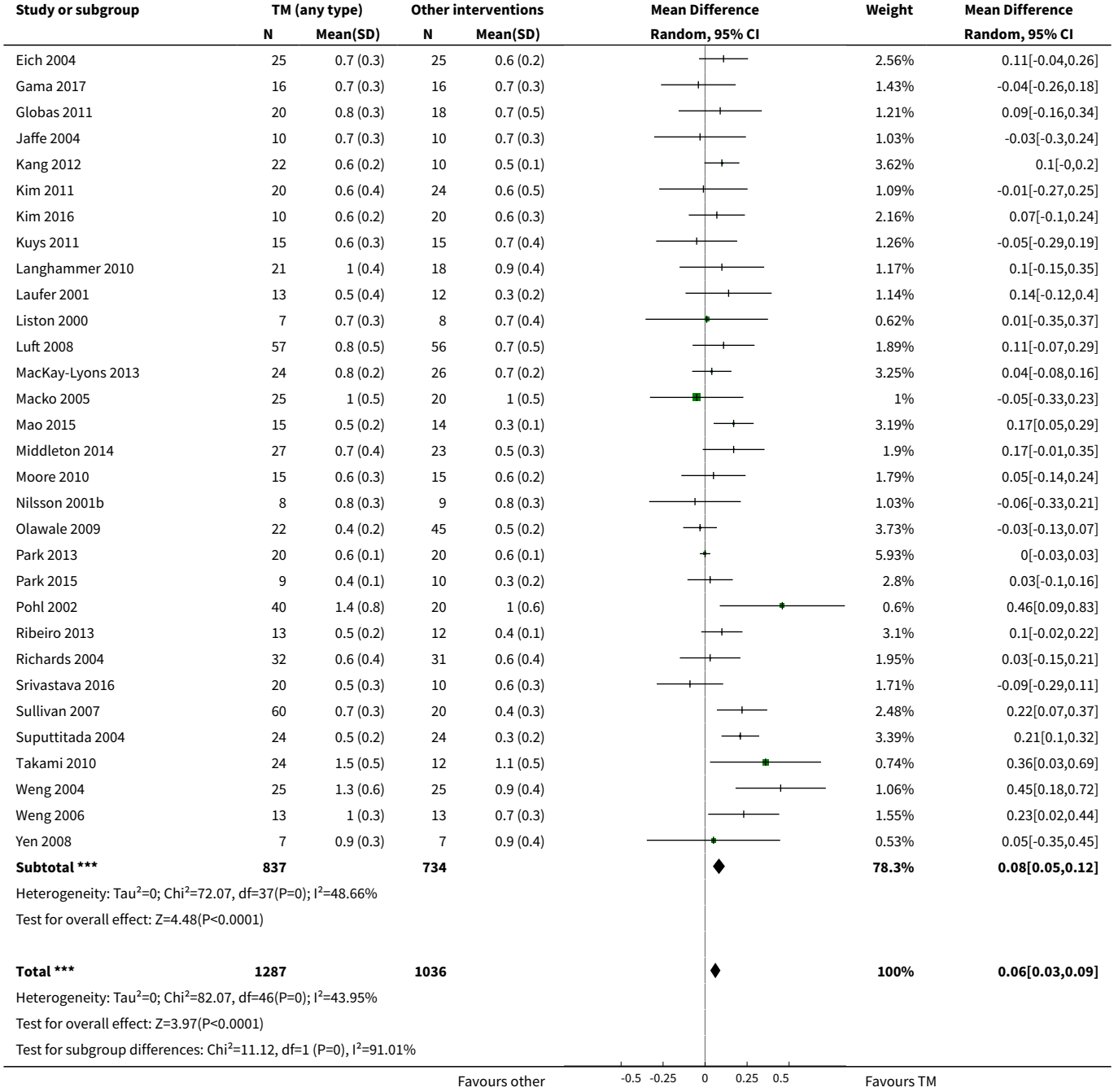
DATA AND ANALYSES

Comparison 1. Treadmill (with or without body weight support) versus other intervention

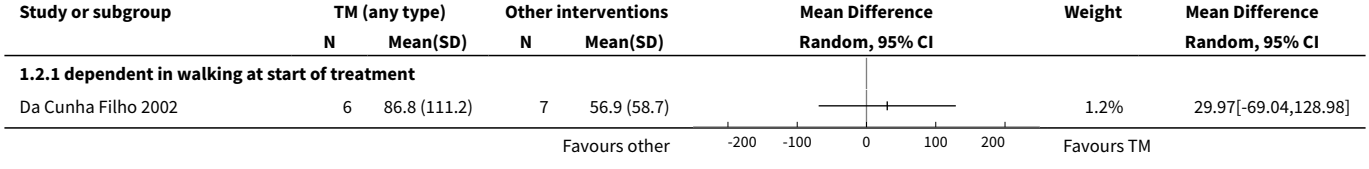
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed (m/s) at end of treatment	47	2323	Mean Difference (IV, Random, 95% CI)	0.06 [0.03, 0.09]
1.1 dependent in walking at start of treatment	9	752	Mean Difference (IV, Random, 95% CI)	-0.01 [-0.06, 0.03]
1.2 independent in walking at start of treatment	38	1571	Mean Difference (IV, Random, 95% CI)	0.08 [0.05, 0.12]
2 Walking endurance (m) at end of treatment	28	1680	Mean Difference (IV, Random, 95% CI)	14.19 [2.92, 25.46]
2.1 dependent in walking at start of treatment	5	639	Mean Difference (IV, Random, 95% CI)	-5.09 [-23.41, 13.22]
2.2 independent in walking at start of treatment	23	1041	Mean Difference (IV, Random, 95% CI)	19.72 [6.61, 32.83]

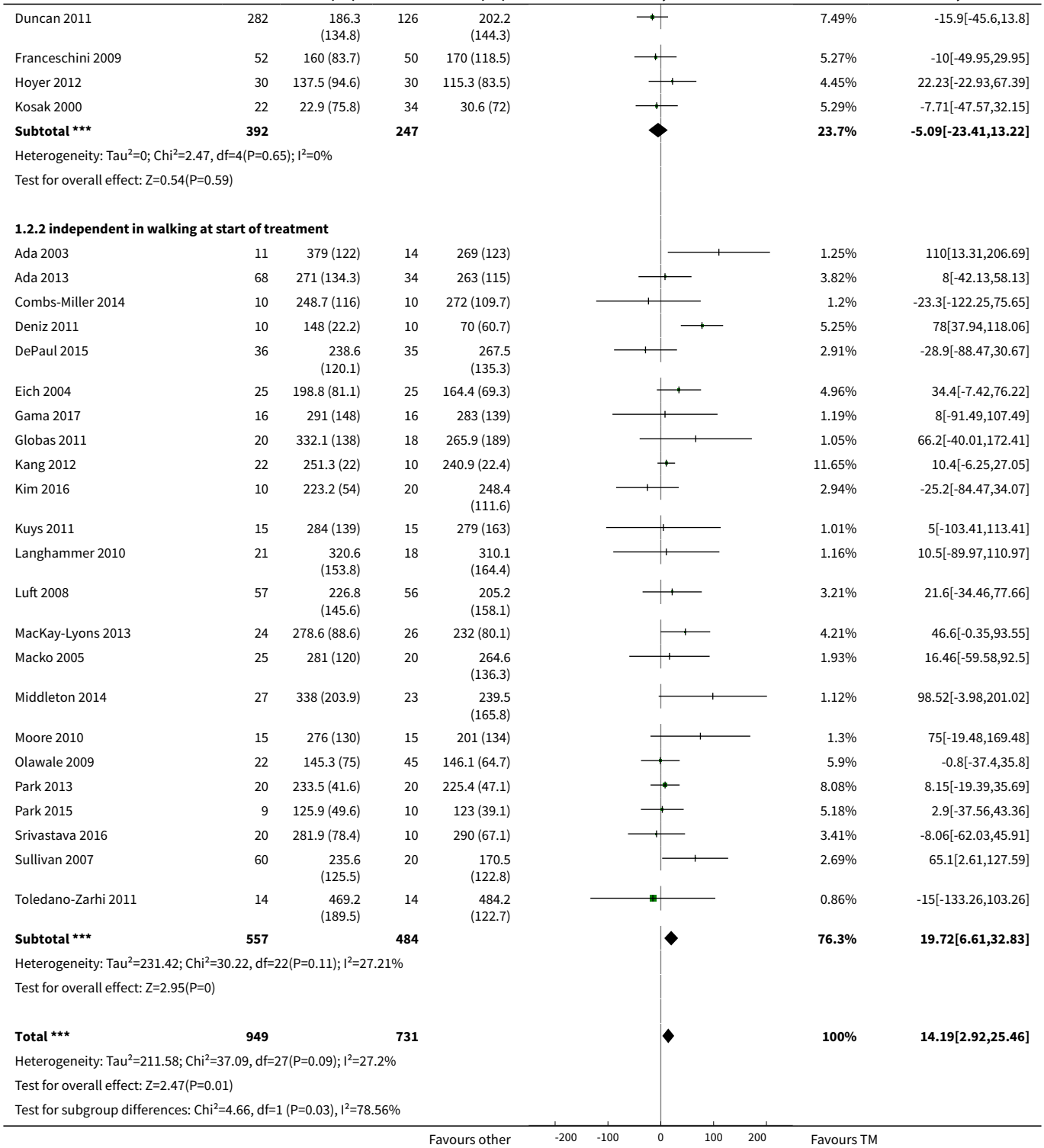
Analysis 1.1. Comparison 1 Treadmill (with or without body weight support) versus other intervention, Outcome 1 Walking speed (m/s) at end of treatment.

Study or subgroup	TM (any type) N	TM (any type) Mean(SD)	Other interventions N	Other interventions Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
1.1.1 dependent in walking at start of treatment							
Da Cunha Filho 2002	6	0.3 (0.4)	7	0.3 (0.3)		0.57%	0.06[-0.32,0.44]
Duncan 2011	282	0.6 (0.4)	126	0.6 (0.4)		4.15%	-0.05[-0.14,0.04]
Franceschini 2009	52	0.5 (0.4)	50	0.6 (0.4)		2.1%	-0.1[-0.27,0.07]
Hoyer 2012	30	0.4 (0.3)	30	0.4 (0.2)		2.93%	0.04[-0.09,0.17]
Kosak 2000	22	0.1 (0.2)	34	0.1 (0.2)		3.91%	-0.01[-0.1,0.08]
Nilsson 2001a	24	0.5 (0.4)	25	0.5 (0.4)		1.55%	0.05[-0.16,0.26]
Richards 1993	9	0.3 (0.2)	5	0.2 (0.9)		0.13%	0.08[-0.75,0.91]
Werner 2002a	15	0.1 (0.2)	15	0.1 (0.2)		2.78%	-0.04[-0.18,0.1]
Zhu 2004	10	0.2 (0.1)	10	0.2 (0.1)		3.57%	0.02[-0.09,0.13]
Subtotal ***	**450**		**302**			**21.7%**	**-0.01[-0.06,0.03]**
Heterogeneity: Tau²=0; Chi²=3.39, df=8(P=0.91); I²=0%							
Test for overall effect: Z=0.65(P=0.52)							
1.1.2 independent in walking at start of treatment							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		1.46%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		3.03%	0.09[-0.04,0.22]
Bonnyaud 2013	13	0.9 (0.2)	13	0.9 (0.2)		2.9%	-0.02[-0.15,0.11]
Bonnyaud 2013a	30	0.9 (0.2)	30	0.8 (0.2)		3.46%	0.04[-0.07,0.15]
Combs-Miller 2014	10	0.7 (0.2)	10	0.8 (0.3)		1.41%	-0.12[-0.34,0.1]
Deniz 2011	10	0.5 (0.2)	10	0.2 (0.1)		2.74%	0.25[0.11,0.39]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		2.4%	0.08[-0.07,0.23]
				Favours other	-0.5 -0.25 0 0.25 0.5	Favours TM	



Analysis 1.2. Comparison 1 Treadmill (with or without body weight support) versus other intervention, Outcome 2 Walking endurance (m) at end of treatment.



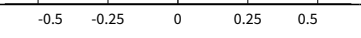


Comparison 2. Treadmill and body weight support versus other interventions

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Dependence on personal assistance to walk at end of treatment	19	1210	Risk Difference (M-H, Random, 95% CI)	-0.00 [-0.02, 0.02]
1.1 dependent in walking at start of treatment	8	814	Risk Difference (M-H, Random, 95% CI)	-0.00 [-0.03, 0.03]
1.2 independent in walking at start of treatment	11	396	Risk Difference (M-H, Random, 95% CI)	0.0 [-0.03, 0.03]
2 Walking speed (m/s) at end of treatment	26	1410	Mean Difference (IV, Random, 95% CI)	0.07 [0.02, 0.11]
2.1 dependent in walking at start of treatment	8	738	Mean Difference (IV, Random, 95% CI)	-0.01 [-0.06, 0.03]
2.2 independent in walking at start of treatment	18	672	Mean Difference (IV, Random, 95% CI)	0.11 [0.06, 0.17]
3 Walking endurance (m) at end of treatment	15	1062	Mean Difference (IV, Random, 95% CI)	20.79 [0.43, 41.14]
3.1 dependent in walking at start of treatment	5	639	Mean Difference (IV, Random, 95% CI)	-5.09 [-23.41, 13.22]
3.2 independent in walking at start of treatment	10	423	Mean Difference (IV, Random, 95% CI)	36.91 [11.14, 62.68]
4 Dependence on personal assistance to walk at end of scheduled follow-up	5	285	Risk Difference (M-H, Random, 95% CI)	-0.00 [-0.05, 0.04]
4.1 dependent in walking at start of treatment	2	170	Risk Difference (M-H, Random, 95% CI)	-0.02 [-0.18, 0.15]
4.2 independent in walking at start of treatment	3	115	Risk Difference (M-H, Random, 95% CI)	0.0 [-0.05, 0.05]
5 Walking speed (m/s) at end of scheduled follow-up	12	944	Mean Difference (IV, Random, 95% CI)	0.03 [-0.05, 0.10]
5.1 dependent in walking at start of treatment	3	556	Mean Difference (IV, Random, 95% CI)	-0.05 [-0.13, 0.03]
5.2 independent in walking at start of treatment	9	388	Mean Difference (IV, Random, 95% CI)	0.06 [-0.03, 0.15]
6 Walking endurance (m) at end of scheduled follow-up	10	882	Mean Difference (IV, Random, 95% CI)	21.64 [-4.70, 47.98]
6.1 dependent in walking at start of treatment	2	510	Mean Difference (IV, Random, 95% CI)	-6.78 [-34.57, 21.02]
6.2 independent in walking at start of treatment	8	372	Mean Difference (IV, Random, 95% CI)	31.55 [0.57, 62.53]

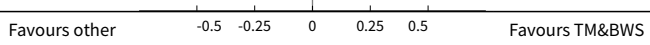
Analysis 2.1. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 1 Dependence on personal assistance to walk at end of treatment.

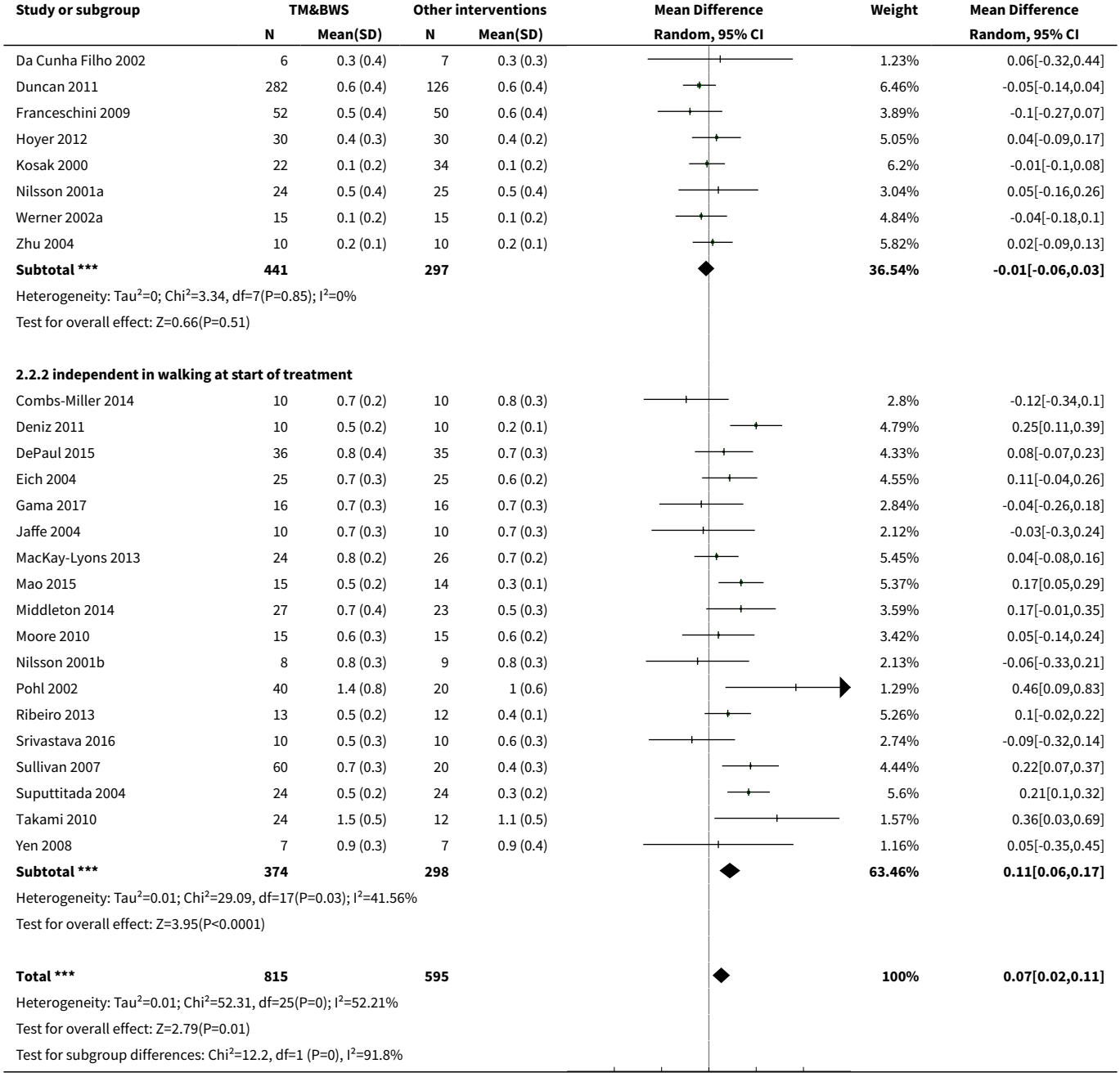
Study or subgroup	TM&BWS	Other interventions	Risk Difference	Weight	Risk Difference
	n/N	n/N	M-H, Random, 95% CI		M-H, Random, 95% CI
2.1.1 dependent in walking at start of treatment					
Ada 2010	40/64	48/62		2.03%	-0.15[-0.31,0.01]
Da Cunha Filho 2002	3/6	3/7		0.17%	0.07[-0.47,0.61]
Duncan 2011	135/282	61/126		4.58%	-0.01[-0.11,0.1]
Franceschini 2009	0/52	0/50		35.82%	0[-0.04,0.04]
Kosak 2000	20/22	28/34		1.64%	0.09[-0.09,0.26]
Nilsson 2001a	4/24	4/25		1.18%	0.01[-0.2,0.21]
Scheidtmann 1999	10/15	11/15		0.47%	-0.07[-0.39,0.26]
Werner 2002a	13/15	10/15		0.58%	0.2[-0.09,0.49]
Subtotal (95% CI)	**480**	**334**		**46.46%**	**-0[-0.03,0.03]**
Total events: 225 (TM&BWS), 165 (Other interventions)					
Heterogeneity: Tau^2=0; Chi^2=6.92, df=7(P=0.44); I^2=0%					
Test for overall effect: Z=0.1(P=0.92)					
2.1.2 independent in walking at start of treatment					
Ada 2003	0/11	0/14		2.4%	0[-0.15,0.15]
Eich 2004	0/25	0/25		9.05%	0[-0.07,0.07]
Globas 2011	0/20	0/18		5.35%	0[-0.1,0.1]
Jaffe 2004	0/10	0/10		1.66%	0[-0.17,0.17]
MacKay-Lyons 2013	0/24	0/26		9.01%	0[-0.07,0.07]
Nilsson 2001b	0/8	0/9		1.24%	0[-0.2,0.2]
Sullivan 2007	0/60	0/20		10.59%	0[-0.07,0.07]
Suputtitada 2004	0/24	0/24		8.38%	0[-0.08,0.08]
Takami 2010	0/24	0/12		3.62%	0[-0.12,0.12]
Yang 2010	0/10	0/8		1.34%	0[-0.19,0.19]
Yen 2008	0/7	0/7		0.9%	0[-0.24,0.24]
Subtotal (95% CI)	**223**	**173**		**53.54%**	**0[-0.03,0.03]**
Total events: 0 (TM&BWS), 0 (Other interventions)					
Heterogeneity: Tau^2=0; Chi^2=0, df=10(P=1); I^2=0%					
Test for overall effect: Not applicable					
Total (95% CI)	**703**	**507**		**100%**	**-0[-0.02,0.02]**
Total events: 225 (TM&BWS), 165 (Other interventions)					
Heterogeneity: Tau^2=0; Chi^2=6.95, df=18(P=0.99); I^2=0%					
Test for overall effect: Z=0.07(P=0.94)					
Test for subgroup differences: Chi^2=0.01, df=1 (P=0.94), I^2=0%					



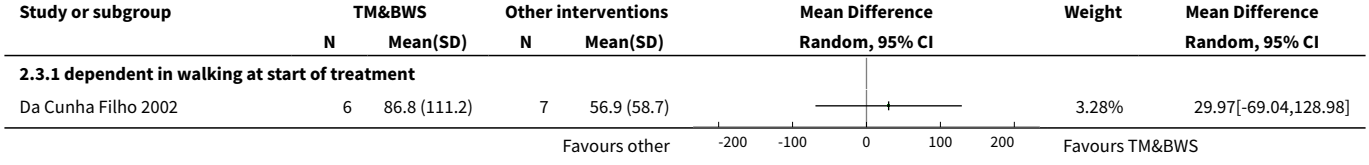
Analysis 2.2. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 2 Walking speed (m/s) at end of treatment.

Study or subgroup	TM&BWS		Other interventions		Mean Difference	Weight	Mean Difference
	N	Mean(SD)	N	Mean(SD)	Random, 95% CI		Random, 95% CI
2.2.1 dependent in walking at start of treatment							

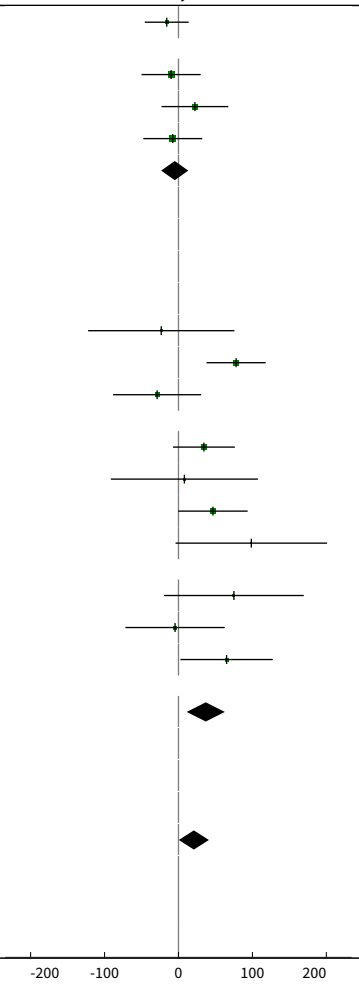




Analysis 2.3. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 3 Walking endurance (m) at end of treatment.

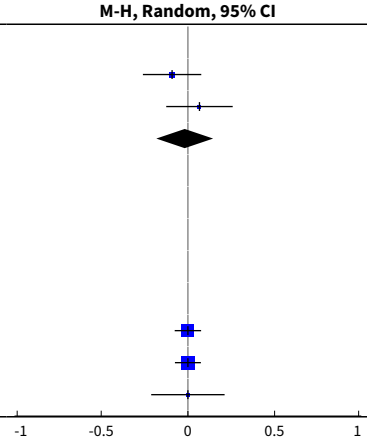


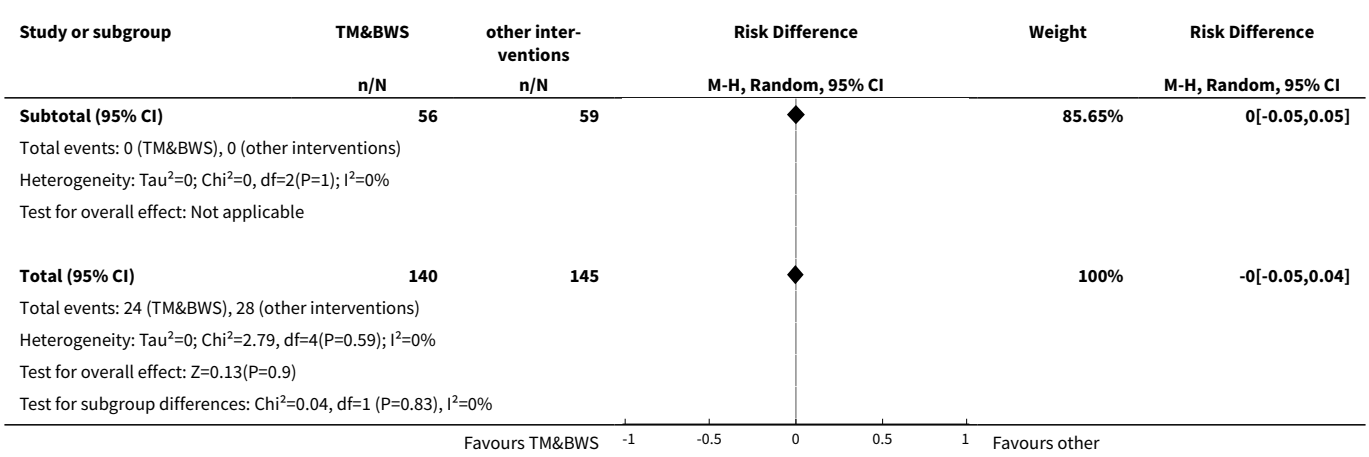
Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	Other interventions N	Other interventions Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
Duncan 2011	282	186.3 (134.8)	126	202.2 (144.3)		11.2%	-15.9[-45.6,13.8]
Franceschini 2009	52	160 (83.7)	50	170 (118.5)		9.39%	-10[-49.95,29.95]
Hoyer 2012	30	137.5 (94.6)	30	115.3 (83.5)		8.53%	22.23[-22.93,67.39]
Kosak 2000	22	22.9 (75.8)	34	30.6 (72)		9.4%	-7.71[-47.57,32.15]
Subtotal ***	**392**		**247**			**41.8%**	**-5.09[-23.41,13.22]**
Heterogeneity: Tau^2=0; Chi^2=2.47, df=4(P=0.65); I^2=0%							
Test for overall effect: Z=0.54(P=0.59)							
2.3.2 independent in walking at start of treatment							
Combs-Miller 2014	10	248.7 (116)	10	272 (109.7)		3.29%	-23.3[-122.25,75.65]
Deniz 2011	10	148 (22.2)	10	70 (60.7)		9.37%	78[37.94,118.06]
DePaul 2015	36	238.6 (120.1)	35	267.5 (135.3)		6.51%	-28.9[-88.47,30.67]
Eich 2004	25	198.8 (81.1)	25	164.4 (69.3)		9.07%	34.4[-7.42,76.22]
Gama 2017	16	291 (148)	16	283 (139)		3.26%	8[-91.49,107.49]
MacKay-Lyons 2013	24	278.6 (88.6)	26	232 (80.1)		8.25%	46.6[-0.35,93.55]
Middleton 2014	27	338 (203.9)	23	239.5 (165.8)		3.11%	98.52[-3.98,201.02]
Moore 2010	15	276 (130)	15	201 (134)		3.53%	75[-19.48,169.48]
Srivastava 2016	10	285.4 (85.1)	10	290 (67.1)		5.65%	-4.62[-71.8,62.56]
Sullivan 2007	60	235.6 (125.5)	20	170.5 (122.8)		6.16%	65.1[2.61,127.59]
Subtotal ***	**233**		**190**			**58.2%**	**36.91[11.14,62.68]**
Heterogeneity: Tau^2=627.4; Chi^2=14.8, df=9(P=0.1); I^2=39.2%							
Test for overall effect: Z=2.81(P=0.01)							
Total ***	**625**		**437**			**100%**	**20.79[0.43,41.14]**
Heterogeneity: Tau^2=733.89; Chi^2=28.66, df=14(P=0.01); I^2=51.15%							
Test for overall effect: Z=2(P=0.05)							
Test for subgroup differences: Chi^2=6.78, df=1 (P=0.01), I^2=85.25%							



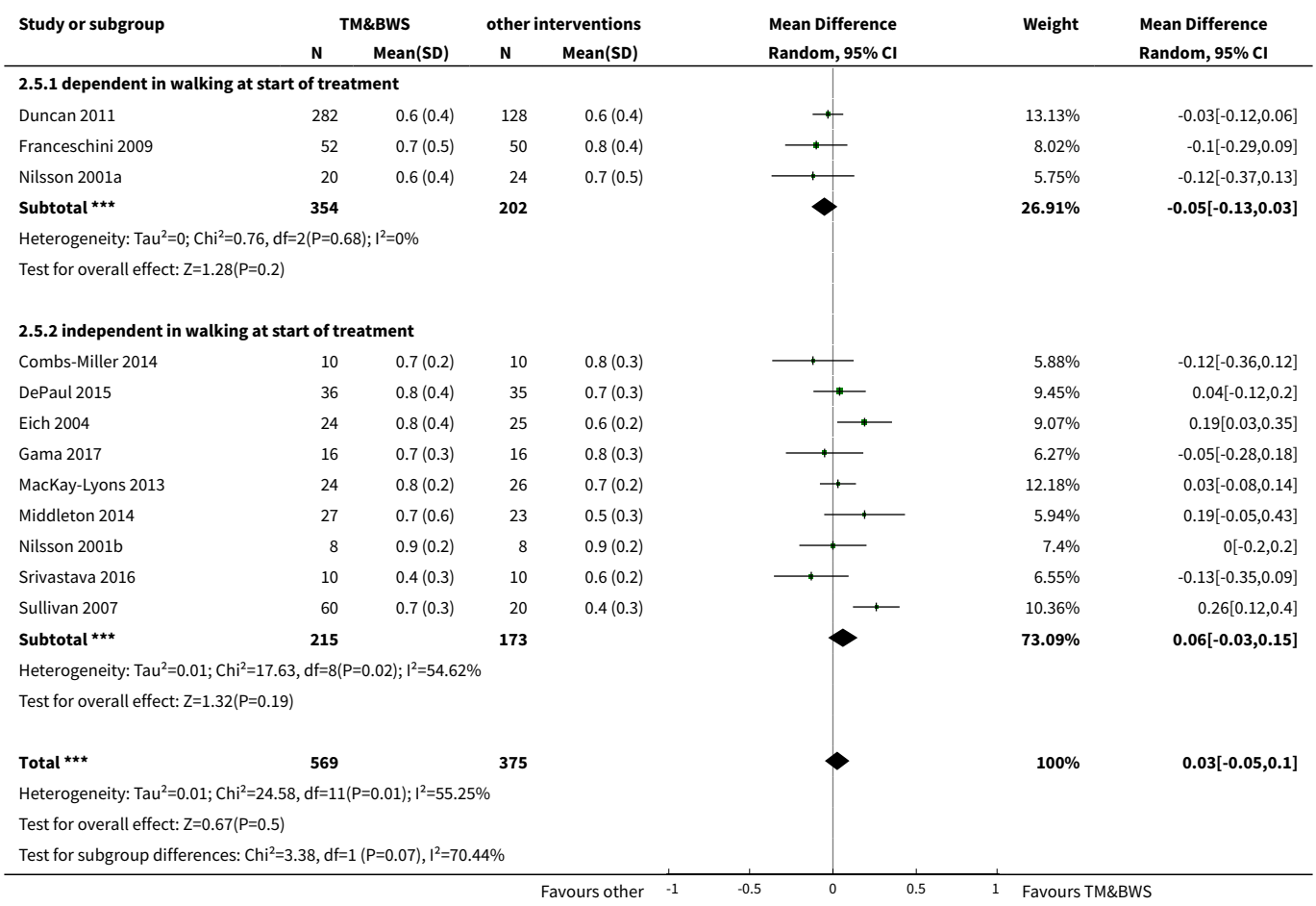
Analysis 2.4. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 4 Dependence on personal assistance to walk at end of scheduled follow-up.

Study or subgroup	TM&BWS n/N	other inter-ventions n/N	Risk Difference M-H, Random, 95% CI	Weight	Risk Difference M-H, Random, 95% CI
2.4.1 dependent in walking at start of treatment					
Ada 2010	21/64	26/62		8.1%	-0.09[-0.26,0.08]
Nilsson 2001a	3/20	2/24		6.25%	0.07[-0.12,0.26]
Subtotal (95% CI)	**84**	**86**		**14.35%**	**-0.02[-0.18,0.15]**
Total events: 24 (TM&BWS), 28 (other interventions)					
Heterogeneity: Tau^2=0.01; Chi^2=1.66, df=1(P=0.2); I^2=39.86%					
Test for overall effect: Z=0.22(P=0.83)					
2.4.2 independent in walking at start of treatment					
Eich 2004	0/24	0/25		39.56%	0[-0.08,0.08]
MacKay-Lyons 2013	0/24	0/26		40.98%	0[-0.07,0.07]
Nilsson 2001b	0/8	0/8		5.12%	0[-0.21,0.21]

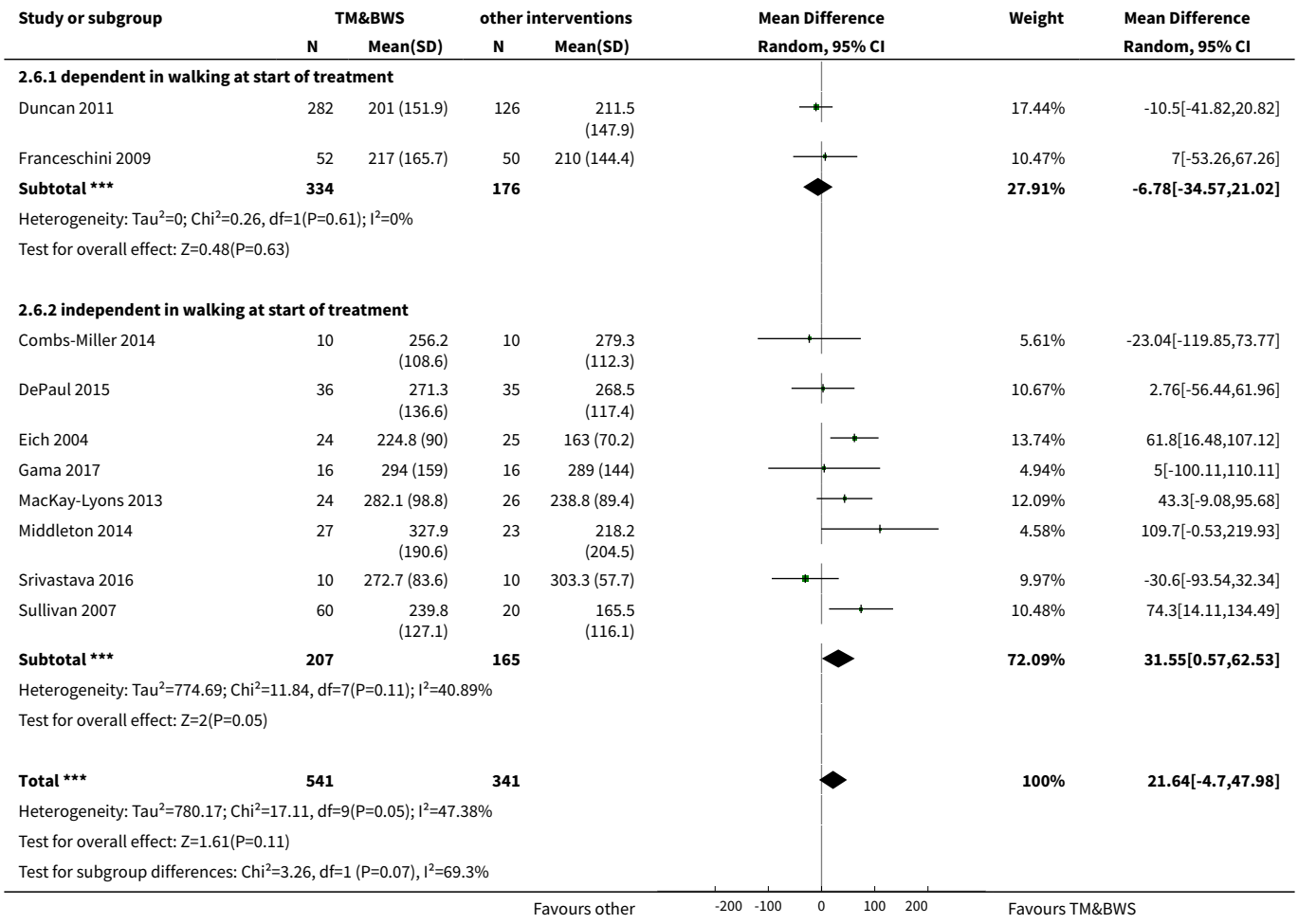




Analysis 2.5. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 5 Walking speed (m/s) at end of scheduled follow-up.



Analysis 2.6. Comparison 2 Treadmill and body weight support versus other interventions, Outcome 6 Walking endurance (m) at end of scheduled follow-up.

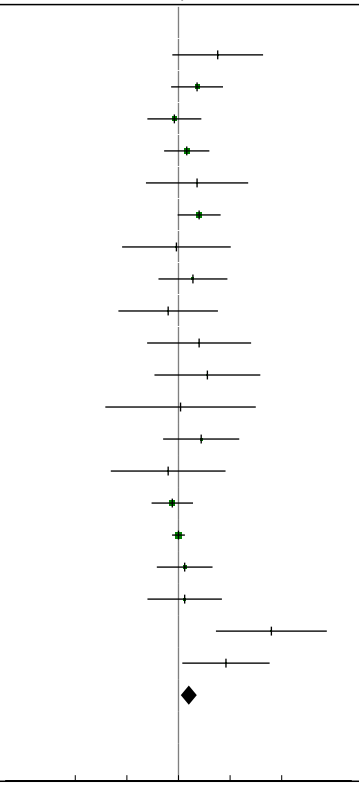


Comparison 3. Treadmill training without body weight support versus other interventions

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed (m/s) at end of treatment	20		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1 independent in walking at start of treatment	20	889	Mean Difference (IV, Random, 95% CI)	0.05 [0.01, 0.09]
2 Walking endurance (m) at end of treatment	13		Mean Difference (IV, Random, 95% CI)	Subtotals only
2.1 independent in walking at start of treatment	13	608	Mean Difference (IV, Random, 95% CI)	9.25 [-1.99, 20.50]

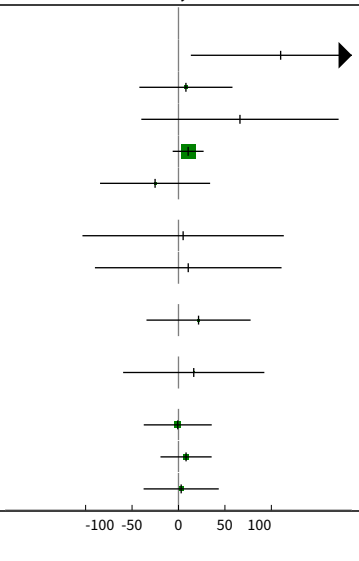
Analysis 3.1. Comparison 3 Treadmill training without body weight support versus other interventions, Outcome 1 Walking speed (m/s) at end of treatment.

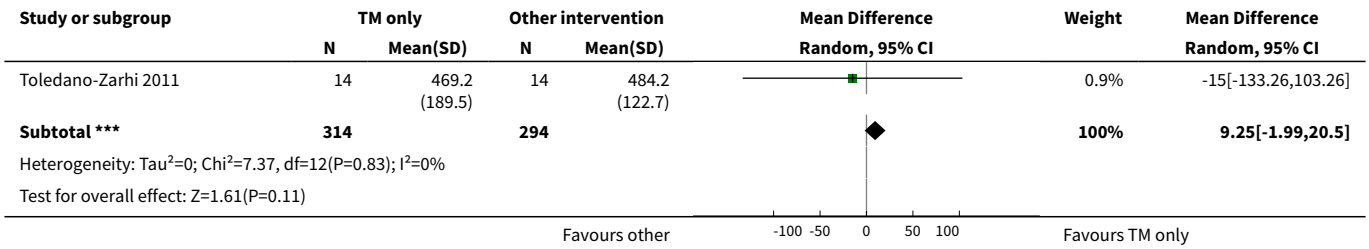
Study or subgroup	TM only N	TM only Mean(SD)	Other interventions N	Other interventions Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
3.1.1 independent in walking at start of treatment							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		2.75%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		6.83%	0.09[-0.04,0.22]
Bonnyaud 2013	13	0.9 (0.2)	13	0.9 (0.2)		6.45%	-0.02[-0.15,0.11]
Bonnyaud 2013a	30	0.9 (0.2)	30	0.8 (0.2)		8.25%	0.04[-0.07,0.15]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		2.22%	0.09[-0.16,0.34]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		8.82%	0.1[-0,0.2]
Kim 2011	20	0.6 (0.4)	24	0.6 (0.5)		1.99%	-0.01[-0.27,0.25]
Kim 2016	10	0.6 (0.2)	20	0.6 (0.3)		4.4%	0.07[-0.1,0.24]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		2.33%	-0.05[-0.29,0.19]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		2.15%	0.1[-0.15,0.35]
Laufer 2001	13	0.5 (0.4)	12	0.3 (0.2)		2.09%	0.14[-0.12,0.4]
Liston 2000	7	0.7 (0.3)	8	0.7 (0.4)		1.08%	0.01[-0.35,0.37]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		3.73%	0.11[-0.07,0.29]
Macko 2005	25	1 (0.5)	20	1 (0.5)		1.8%	-0.05[-0.33,0.23]
Olawale 2009	22	0.4 (0.2)	45	0.5 (0.2)		9.23%	-0.03[-0.13,0.07]
Park 2013	20	0.6 (0.1)	20	0.6 (0.1)		21%	0[-0.03,0.03]
Park 2015	9	0.4 (0.1)	10	0.3 (0.2)		6.15%	0.03[-0.1,0.16]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		3.87%	0.03[-0.15,0.21]
Weng 2004	25	1.3 (0.6)	25	0.9 (0.4)		1.92%	0.45[0.18,0.72]
Weng 2006	13	1 (0.3)	13	0.7 (0.3)		2.95%	0.23[0.02,0.44]
Subtotal ***	**453**		**436**			**100%**	**0.05[0.01,0.09]**
Heterogeneity: Tau^2=0; Chi^2=25.8, df=19(P=0.14); I^2=26.36%							
Test for overall effect: Z=2.53(P=0.01)							



Analysis 3.2. Comparison 3 Treadmill training without body weight support versus other interventions, Outcome 2 Walking endurance (m) at end of treatment.

Study or subgroup	TM only N	TM only Mean(SD)	Other intervention N	Other intervention Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
3.2.1 independent in walking at start of treatment							
Ada 2003	11	379 (122)	14	269 (123)		1.35%	110[13.31,206.69]
Ada 2013	68	271 (134.3)	34	263 (115)		5.03%	8[-42.13,58.13]
Globas 2011	20	332.1 (138)	18	265.9 (189)		1.12%	66.2[-40.01,172.41]
Kang 2012	22	251.3 (22)	10	240.9 (22.4)		45.61%	10.4[-6.25,27.05]
Kim 2016	10	223.2 (54)	20	248.4 (111.6)		3.6%	-25.2[-84.47,34.07]
Kuys 2011	15	284 (139)	15	279 (163)		1.08%	5[-103.41,113.41]
Langhammer 2010	21	320.6 (153.8)	18	310.1 (164.4)		1.25%	10.5[-89.97,110.97]
Luft 2008	57	226.8 (145.6)	56	205.2 (158.1)		4.02%	21.6[-34.46,77.66]
Macko 2005	25	281 (120)	20	264.6 (136.3)		2.19%	16.43[-59.61,92.47]
Olawale 2009	22	145.3 (75)	45	146.1 (64.7)		9.44%	-0.8[-37.4,35.8]
Park 2013	20	233.5 (41.6)	20	225.4 (47.1)		16.67%	8.15[-19.39,35.69]
Park 2015	9	125.9 (49.6)	10	123 (39.1)		7.72%	2.9[-37.56,43.36]





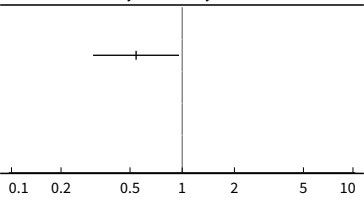
Comparison 4. Treadmill and body weight support versus treadmill only

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Dependence on personal assistance to walk at end of treatment	2		Risk Ratio (M-H, Random, 95% CI)	Totals not selected
1.1 dependent in walking at start of treatment	1		Risk Ratio (M-H, Random, 95% CI)	0.0 [0.0, 0.0]
1.2 independent in walking at start of treatment	1		Risk Ratio (M-H, Random, 95% CI)	0.0 [0.0, 0.0]
2 Walking speed (m/s) at end of treatment	3		Mean Difference (IV, Random, 95% CI)	Totals not selected
2.1 dependent in walking at start of treatment	1		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
2.2 independent in walking at start of treatment	2		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3 Walking endurance (m) at end of treatment	3		Mean Difference (IV, Random, 95% CI)	Totals not selected
3.1 dependent in walking at start of treatment	1		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
3.2 independent in walking at start of treatment	2		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
4 Dependence on personal assistance to walk at end of scheduled follow-up	2		Risk Ratio (M-H, Random, 95% CI)	Totals not selected
4.1 dependent in walking at start of treatment	1		Risk Ratio (M-H, Random, 95% CI)	0.0 [0.0, 0.0]
4.2 independent in walking at start of treatment	1		Risk Ratio (M-H, Random, 95% CI)	0.0 [0.0, 0.0]
5 Walking speed (m/s) at end of scheduled follow-up	3		Mean Difference (IV, Random, 95% CI)	Totals not selected
5.1 dependent in walking at start of treatment	1		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
5.2 independent in walking at start of treatment	2		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6 Walking endurance (m) at end of scheduled follow-up	3		Mean Difference (IV, Random, 95% CI)	Totals not selected
6.1 dependent in walking at start of treatment	1		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]
6.2 independent in walking at start of treatment	2		Mean Difference (IV, Random, 95% CI)	0.0 [0.0, 0.0]

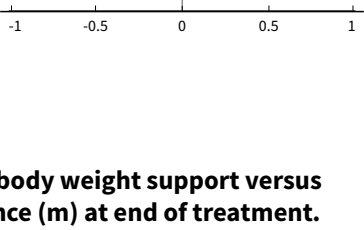
Analysis 4.1. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 1 Dependence on personal assistance to walk at end of treatment.

Study or subgroup	TM&BWS n/N	TM only n/N	Risk Ratio M-H, Random, 95% CI	Risk Ratio M-H, Random, 95% CI
4.1.1 dependent in walking at start of treatment				
Visintin 1998a	11/33	16/26		0.54[0.31,0.96]
4.1.2 independent in walking at start of treatment				
Visintin 1998b	0/10	0/10		Not estimable



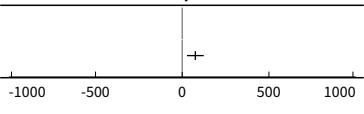
Analysis 4.2. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 2 Walking speed (m/s) at end of treatment.

Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	TM only N	TM only Mean(SD)	Mean Difference Random, 95% CI	Mean Difference Random, 95% CI
4.2.1 dependent in walking at start of treatment						
Visintin 1998a	33	0.3 (0.2)	26	0.1 (0.2)		0.15[0.05,0.25]
4.2.2 independent in walking at start of treatment						
Srivastava 2016	10	0.5 (0.3)	10	0.5 (0.3)		0.01[-0.23,0.25]
Visintin 1998b	10	0.6 (0.3)	10	0.5 (0.2)		0.1[-0.14,0.34]

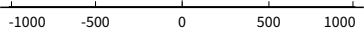


Analysis 4.3. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 3 Walking endurance (m) at end of treatment.

Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	TM only N	TM only Mean(SD)	Mean Difference Random, 95% CI	Mean Difference Random, 95% CI
4.3.1 dependent in walking at start of treatment						
Visintin 1998a	33	107.6 (119.4)	26	32 (67.5)		75.64[27.34,123.94]



Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	TM only N	TM only Mean(SD)	Mean Difference Random, 95% CI	Mean Difference Random, 95% CI
4.3.2 independent in walking at start of treatment						
Srivastava 2016	10	285.4 (85.1)	10	278.5 (71.7)		6.88[-62.11,75.87]
Visintin 1998b	10	234 (114.8)	10	241.6 (89.4)		-7.6[-97.77,82.57]

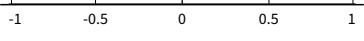


Analysis 4.4. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 4 Dependence on personal assistance to walk at end of scheduled follow-up.

Study or subgroup	TM&BWS n/N	TM only n/N	Risk Ratio M-H, Random, 95% CI	Risk Ratio M-H, Random, 95% CI
4.4.1 dependent in walking at start of treatment				
Visintin 1998a	2/21	6/17		0.27[0.06,1.17]
4.4.2 independent in walking at start of treatment				
Visintin 1998b	0/8	0/6		Not estimable

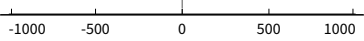
Analysis 4.5. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 5 Walking speed (m/s) at end of scheduled follow-up.

Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	TM only N	TM only Mean(SD)	Mean Difference Random, 95% CI	Mean Difference Random, 95% CI
4.5.1 dependent in walking at start of treatment						
Visintin 1998a	20	0.4 (0.3)	15	0.2 (0.2)		0.24[0.07,0.41]
4.5.2 independent in walking at start of treatment						
Srivastava 2016	10	0.4 (0.3)	10	0.4 (0.3)		0[-0.25,0.25]
Visintin 1998b	8	0.7 (0.4)	6	0.6 (0.2)		0.12[-0.18,0.42]



Analysis 4.6. Comparison 4 Treadmill and body weight support versus treadmill only, Outcome 6 Walking endurance (m) at end of scheduled follow-up.

Study or subgroup	TM&BWS N	TM&BWS Mean(SD)	TM only N	TM only Mean(SD)	Mean Difference Random, 95% CI	Mean Difference Random, 95% CI
4.6.1 dependent in walking at start of treatment						
Visintin 1998a	20	164.8 (122.6)	15	73.9 (110.6)		90.93[13.34,168.52]
4.6.2 independent in walking at start of treatment						
Srivastava 2016	10	272.7 (83.6)	10	289.1 (72.3)		-16.36[-84.84,52.12]
Visintin 1998b	8	266.3 (74.3)	6	275.3 (109.4)		-9.08[-110.62,92.46]

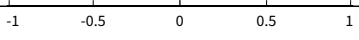


Comparison 5. Adverse events for all included trials

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Adverse events during the treatment	24	1504	Risk Difference (M-H, Random, 95% CI)	0.02 [-0.01, 0.05]

Analysis 5.1. Comparison 5 Adverse events for all included trials, Outcome 1 Adverse events during the treatment.

Study or subgroup	Treatment n/N	Control n/N	Risk Difference M-H, Random, 95% CI	Weight	Risk Difference M-H, Random, 95% CI
Ada 2003	3/14	0/15		1.18%	0.21[-0.02,0.44]
Ada 2010	0/64	0/62		9.32%	0[-0.03,0.03]
Da Cunha Filho 2002	0/7	0/8		1.23%	0[-0.22,0.22]
Duncan 2011	104/282	35/126		4.43%	0.09[-0.01,0.19]
Eich 2004	0/25	0/25		5.78%	0[-0.07,0.07]
Franceschini 2009	2/52	0/50		6.64%	0.04[-0.02,0.1]
Gama 2017	0/16	0/16		3.61%	0[-0.11,0.11]
Jaffe 2004	0/11	0/12		2.32%	0[-0.15,0.15]
Kim 2011	0/20	0/24		5.08%	0[-0.09,0.09]
Kosak 2000	0/22	0/34		6.01%	0[-0.07,0.07]
Kuys 2011	0/15	0/15		3.33%	0[-0.12,0.12]
Laufer 2001	0/15	0/14		3.18%	0[-0.12,0.12]
Liston 2000	2/10	0/8		0.78%	0.2[-0.09,0.49]
MacKay-Lyons 2013	0/24	0/26		5.77%	0[-0.07,0.07]
Macko 2005	11/32	0/29		2.01%	0.34[0.17,0.51]
Nilsson 2001	0/36	0/37		7.56%	0[-0.05,0.05]
Pohl 2002	1/44	0/25		5.8%	0.02[-0.05,0.1]
Richards 1993	0/10	0/8		1.6%	0[-0.19,0.19]
Richards 2004	2/32	1/31		4.02%	0.03[-0.07,0.13]
Scheidtmann 1999	0/15	0/15		3.33%	0[-0.12,0.12]
Smith 2008	0/10	0/10		1.91%	0[-0.17,0.17]
Toledano-Zarhi 2011	0/14	0/14		3.05%	0[-0.13,0.13]
Visintin 1998	0/50	0/50		8.71%	0[-0.04,0.04]
Werner 2002a	0/15	0/15		3.33%	0[-0.12,0.12]
Total (95% CI)	**835**	**669**		**100%**	**0.02[-0.01,0.05]**
Total events: 125 (Treatment), 36 (Control)					
Heterogeneity: Tau^2=0; Chi^2=46.53, df=23(P=0); I^2=50.56%					
Test for overall effect: Z=1.48(P=0.14)					



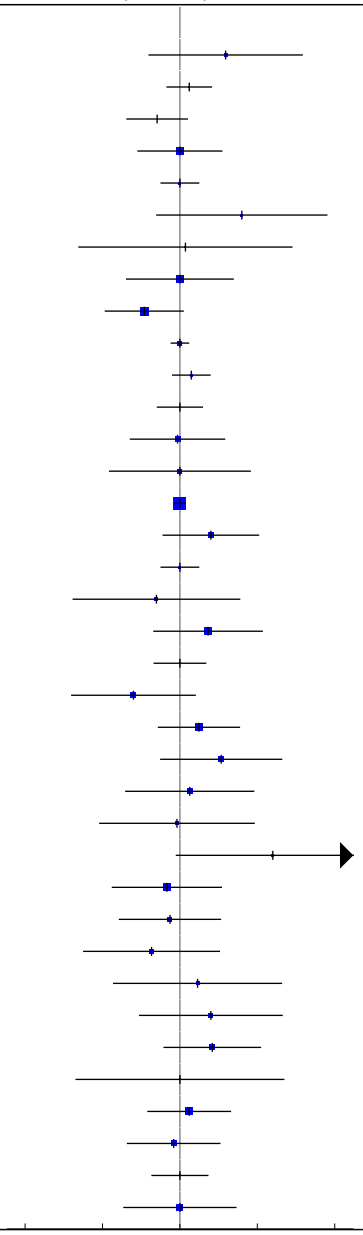
Comparison 6. Dropouts for all included trials

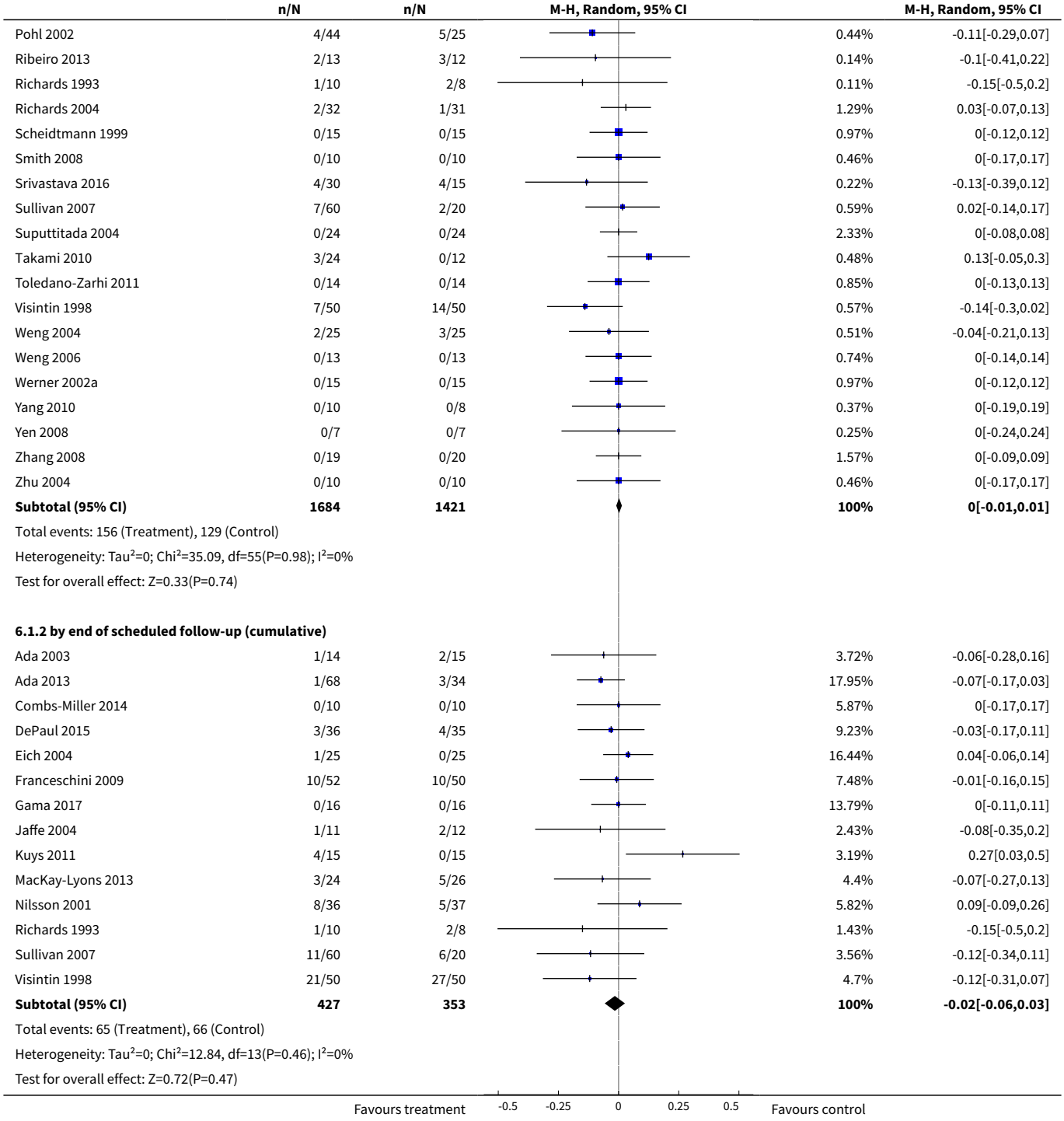
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Dropouts	56		Risk Difference (M-H, Random, 95% CI)	Subtotals only

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1.1 by end of treatment phase	56	3105	Risk Difference (M-H, Random, 95% CI)	0.00 [-0.01, 0.01]
1.2 by end of scheduled follow-up (cumulative)	14	780	Risk Difference (M-H, Random, 95% CI)	-0.02 [-0.06, 0.03]

Analysis 6.1. Comparison 6 Dropouts for all included trials, Outcome 1 Dropouts.

Study or subgroup	Treatment n/N	Control n/N	Risk Difference M-H, Random, 95% CI	Weight	Risk Difference M-H, Random, 95% CI
6.1.1 by end of treatment phase					
Ada 2003	3/14	1/15		0.23%	0.15[-0.1,0.4]
Ada 2010	4/64	2/62		2.58%	0.03[-0.04,0.1]
Ada 2013	1/68	3/34		1.42%	-0.07[-0.17,0.03]
Bonnyaud 2013	0/13	0/13		0.74%	0[-0.14,0.14]
Bonnyaud 2013a	0/30	0/30		3.57%	0[-0.06,0.06]
Combs-Miller 2014	2/10	0/10		0.18%	0.2[-0.08,0.48]
Da Cunha Filho 2002	1/7	1/8		0.12%	0.02[-0.33,0.36]
Deniz 2011	0/10	0/10		0.46%	0[-0.17,0.17]
DePaul 2015	1/36	5/35		0.86%	-0.12[-0.24,0.01]
Du 2006	0/67	0/61		15.46%	0[-0.03,0.03]
Duncan 2011	35/282	11/126		3.59%	0.04[-0.03,0.1]
Eich 2004	0/25	0/25		2.52%	0[-0.07,0.07]
Franceschini 2009	10/52	10/50		0.59%	-0.01[-0.16,0.15]
Gama 2017	2/16	2/16		0.27%	0[-0.23,0.23]
Gan 2012	0/102	0/103		39.34%	0[-0.02,0.02]
Globas 2011	2/20	0/18		0.58%	0.1[-0.06,0.26]
Hoyer 2012	0/30	0/30		3.57%	0[-0.06,0.06]
Jaffe 2004	1/11	2/12		0.19%	-0.08[-0.35,0.2]
Kang 2012	2/22	0/10		0.45%	0.09[-0.09,0.27]
Kim 2011	0/20	0/24		1.93%	0[-0.09,0.09]
Kim 2016	0/10	3/20		0.35%	-0.15[-0.35,0.05]
Kosak 2000	2/22	1/34		0.8%	0.06[-0.07,0.19]
Kuys 2011	2/15	0/15		0.36%	0.13[-0.06,0.33]
Langhammer 2010	3/21	2/18		0.32%	0.03[-0.18,0.24]
Laufer 2001	2/15	2/14		0.22%	-0.01[-0.26,0.24]
Liston 2000	3/10	0/8		0.14%	0.3[-0.01,0.61]
Luft 2008	20/57	22/56		0.44%	-0.04[-0.22,0.14]
MacKay-Lyons 2013	2/24	3/26		0.51%	-0.03[-0.2,0.13]
Macko 2005	7/32	9/29		0.29%	-0.09[-0.31,0.13]
Mao 2015	3/15	2/14		0.19%	0.06[-0.22,0.33]
Mehrberg 2001	1/10	0/11		0.26%	0.1[-0.13,0.33]
Middleton 2014	4/27	1/23		0.56%	0.1[-0.05,0.26]
Moore 2010	5/15	5/15		0.12%	0[-0.34,0.34]
Nilsson 2001	4/36	3/37		0.77%	0.03[-0.11,0.17]
Olawale 2009	2/22	5/45		0.61%	-0.02[-0.17,0.13]
Park 2013	0/20	0/20		1.65%	0[-0.09,0.09]
Park 2015	0/9	0/10		0.42%	0[-0.18,0.18]



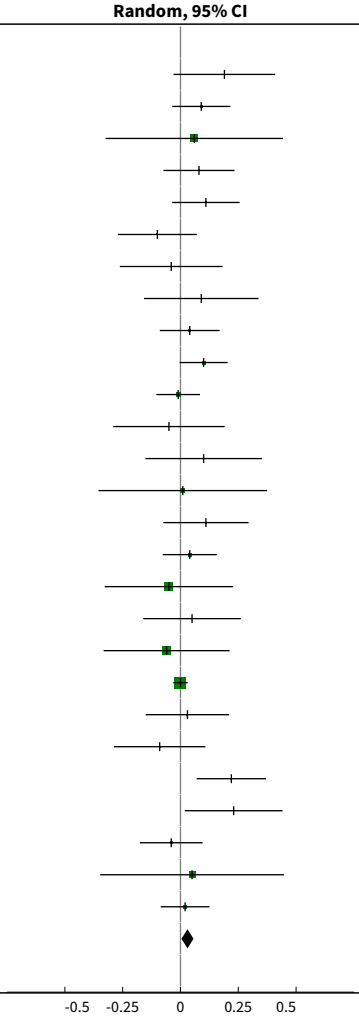


Comparison 7. Sensitivity analysis: by trial methodology (all trials involving treadmill training)

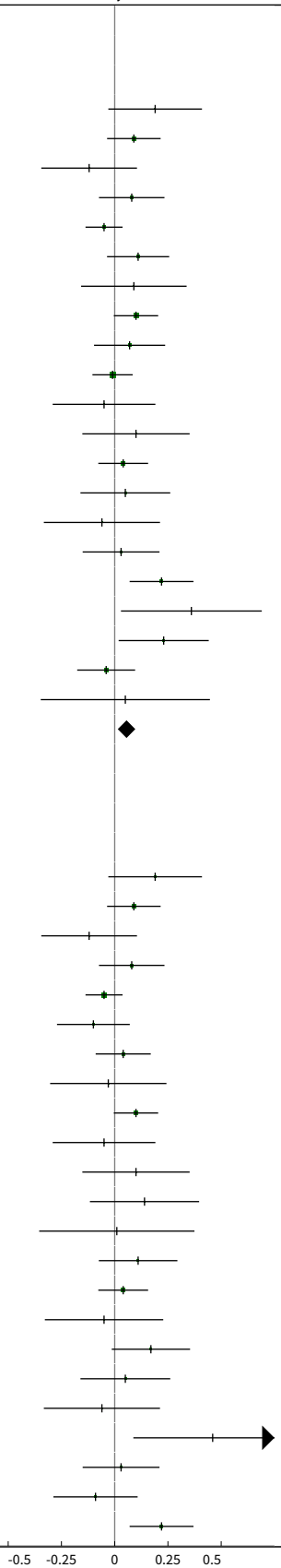
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed	36		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1 trials with adequate random sequence generation	27	1242	Mean Difference (IV, Random, 95% CI)	0.03 [0.00, 0.06]
1.2 trials with adequate concealed allocation	21	1266	Mean Difference (IV, Random, 95% CI)	0.06 [0.01, 0.10]
1.3 trials with adequate blinding of assessors	24	1554	Mean Difference (IV, Random, 95% CI)	0.06 [0.02, 0.11]

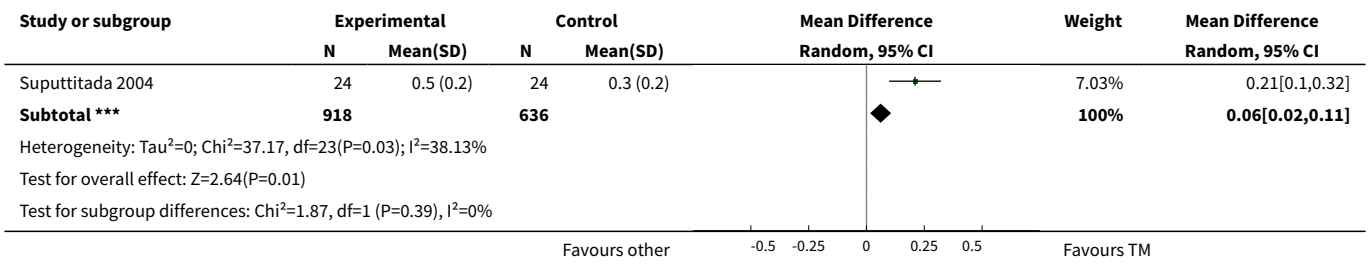
Analysis 7.1. Comparison 7 Sensitivity analysis: by trial methodology (all trials involving treadmill training), Outcome 1 Walking speed.

Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
7.1.1 trials with adequate random sequence generation							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		1.39%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		4.09%	0.09[-0.04,0.22]
Da Cunha Filho 2002	6	0.3 (0.4)	7	0.3 (0.3)		0.46%	0.06[-0.32,0.44]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		2.79%	0.08[-0.07,0.23]
Eich 2004	25	0.7 (0.3)	25	0.6 (0.2)		3.08%	0.11[-0.04,0.26]
Franceschini 2009	52	0.5 (0.4)	50	0.6 (0.4)		2.27%	-0.1[-0.27,0.07]
Gama 2017	16	0.7 (0.3)	16	0.7 (0.3)		1.36%	-0.04[-0.26,0.18]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		1.1%	0.09[-0.16,0.34]
Hoyer 2012	30	0.4 (0.3)	30	0.4 (0.2)		3.88%	0.04[-0.09,0.17]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		5.82%	0.1[-0,0.2]
Kosak 2000	22	0.1 (0.2)	34	0.1 (0.2)		6.95%	-0.01[-0.1,0.08]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		1.16%	-0.05[-0.29,0.19]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		1.06%	0.1[-0.15,0.35]
Liston 2000	7	0.7 (0.3)	8	0.7 (0.4)		0.51%	0.01[-0.35,0.37]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		1.96%	0.11[-0.07,0.29]
MacKay-Lyons 2013	24	0.8 (0.2)	26	0.7 (0.2)		4.69%	0.04[-0.08,0.16]
Macko 2005	25	1 (0.5)	20	1 (0.5)		0.87%	-0.05[-0.33,0.23]
Nilsson 2001a	24	0.5 (0.4)	25	0.5 (0.4)		1.51%	0.05[-0.16,0.26]
Nilsson 2001b	8	0.8 (0.3)	9	0.8 (0.3)		0.91%	-0.06[-0.33,0.21]
Park 2013	20	0.6 (0.1)	20	0.6 (0.1)		36.34%	0[-0.03,0.03]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		2.05%	0.03[-0.15,0.21]
Srivastava 2016	20	0.5 (0.3)	10	0.6 (0.3)		1.71%	-0.09[-0.29,0.11]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		2.92%	0.22[0.07,0.37]
Weng 2006	13	1 (0.3)	13	0.7 (0.3)		1.5%	0.23[0.02,0.44]
Werner 2002a	15	0.1 (0.2)	15	0.1 (0.2)		3.52%	-0.04[-0.18,0.1]
Yen 2008	7	0.9 (0.3)	7	0.9 (0.4)		0.43%	0.05[-0.35,0.45]
Zhu 2004	10	0.2 (0.1)	10	0.2 (0.1)		5.67%	0.02[-0.09,0.13]
Subtotal ***	**666**		**576**			**100%**	**0.03[0,0.06]**
Heterogeneity: Tau^2=0; Chi^2=27.34, df=26(P=0.39); I^2=4.91%							



Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
Test for overall effect: Z=2.27(P=0.02)							
7.1.2 trials with adequate concealed allocation							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		3%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		7.03%	0.09[-0.04,0.22]
Combs-Miller 2014	10	0.7 (0.2)	10	0.8 (0.3)		2.89%	-0.12[-0.34,0.1]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		5.31%	0.08[-0.07,0.23]
Duncan 2011	282	0.6 (0.4)	126	0.6 (0.4)		10.66%	-0.05[-0.14,0.04]
Eich 2004	25	0.7 (0.3)	25	0.6 (0.2)		5.73%	0.11[-0.04,0.26]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		2.44%	0.09[-0.16,0.34]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		8.85%	0.1[-0,0.2]
Kim 2016	10	0.6 (0.2)	20	0.6 (0.3)		4.69%	0.07[-0.1,0.24]
Kosak 2000	22	0.1 (0.2)	34	0.1 (0.2)		9.82%	-0.01[-0.1,0.08]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		2.56%	-0.05[-0.29,0.19]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		2.37%	0.1[-0.15,0.35]
MacKay-Lyons 2013	24	0.8 (0.2)	26	0.7 (0.2)		7.71%	0.04[-0.08,0.16]
Nilsson 2001a	24	0.5 (0.4)	25	0.5 (0.4)		3.22%	0.05[-0.16,0.26]
Nilsson 2001b	8	0.8 (0.3)	9	0.8 (0.3)		2.06%	-0.06[-0.33,0.21]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		4.16%	0.03[-0.15,0.21]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		5.51%	0.22[0.07,0.37]
Takami 2010	24	1.5 (0.5)	12	1.1 (0.5)		1.45%	0.36[0.03,0.69]
Weng 2006	13	1 (0.3)	13	0.7 (0.3)		3.2%	0.23[0.02,0.44]
Werner 2002a	15	0.1 (0.2)	15	0.1 (0.2)		6.33%	-0.04[-0.18,0.1]
Yen 2008	7	0.9 (0.3)	7	0.9 (0.4)		1.02%	0.05[-0.35,0.45]
Subtotal * **	**749**		**517**			**100%**	**0.06[0.01,0.1]**
Heterogeneity: Tau²=0; Chi²=26.91, df=20(P=0.14); I²=25.67%							
Test for overall effect: Z=2.64(P=0.01)							
7.1.3 trials with adequate blinding of assessors							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		3.17%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		6.33%	0.09[-0.04,0.22]
Combs-Miller 2014	10	0.7 (0.2)	10	0.8 (0.3)		3.07%	-0.12[-0.34,0.1]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		5.11%	0.08[-0.07,0.23]
Duncan 2011	282	0.6 (0.4)	126	0.6 (0.4)		8.47%	-0.05[-0.14,0.04]
Franceschini 2009	52	0.5 (0.4)	50	0.6 (0.4)		4.49%	-0.1[-0.27,0.07]
Hoyer 2012	30	0.4 (0.3)	30	0.4 (0.2)		6.16%	0.04[-0.09,0.17]
Jaffe 2004	10	0.7 (0.3)	10	0.7 (0.3)		2.26%	-0.03[-0.3,0.24]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		7.47%	0.1[-0,0.2]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		2.76%	-0.05[-0.29,0.19]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		2.58%	0.1[-0.15,0.35]
Laufer 2001	13	0.5 (0.4)	12	0.3 (0.2)		2.5%	0.14[-0.12,0.4]
Liston 2000	7	0.7 (0.3)	8	0.7 (0.4)		1.38%	0.01[-0.35,0.37]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		4.06%	0.11[-0.07,0.29]
MacKay-Lyons 2013	24	0.8 (0.2)	26	0.7 (0.2)		6.77%	0.04[-0.08,0.16]
Macko 2005	25	1 (0.5)	20	1 (0.5)		2.2%	-0.05[-0.33,0.23]
Middleton 2014	27	0.7 (0.4)	23	0.5 (0.3)		4.08%	0.17[-0.01,0.35]
Nilsson 2001a	24	0.5 (0.4)	25	0.5 (0.4)		3.37%	0.05[-0.16,0.26]
Nilsson 2001b	8	0.8 (0.3)	9	0.8 (0.3)		2.27%	-0.06[-0.33,0.21]
Pohl 2002	40	1.4 (0.8)	20	1 (0.6)		1.33%	0.46[0.09,0.83]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		4.19%	0.03[-0.15,0.21]
Srivastava 2016	20	0.5 (0.3)	10	0.6 (0.3)		3.7%	-0.09[-0.29,0.11]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		5.26%	0.22[0.07,0.37]

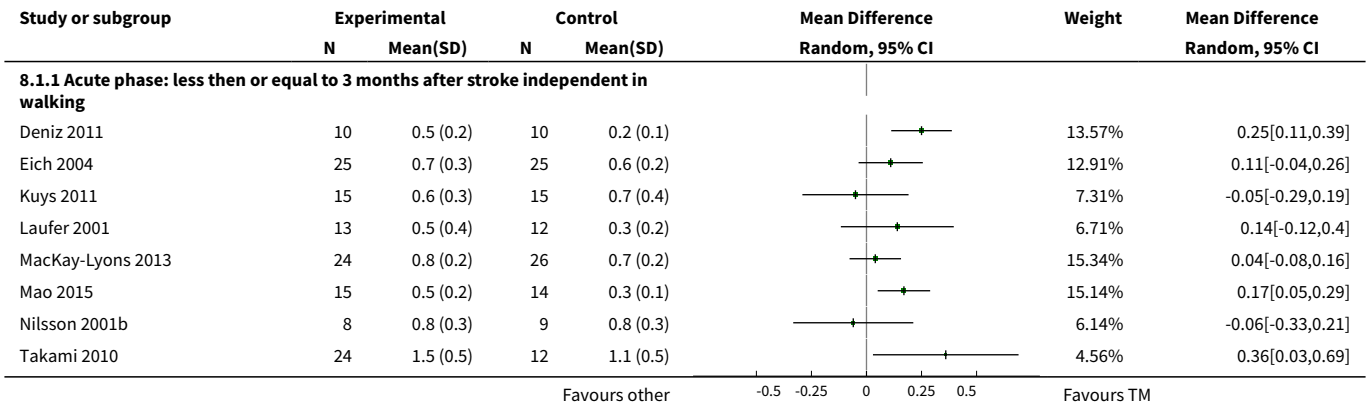


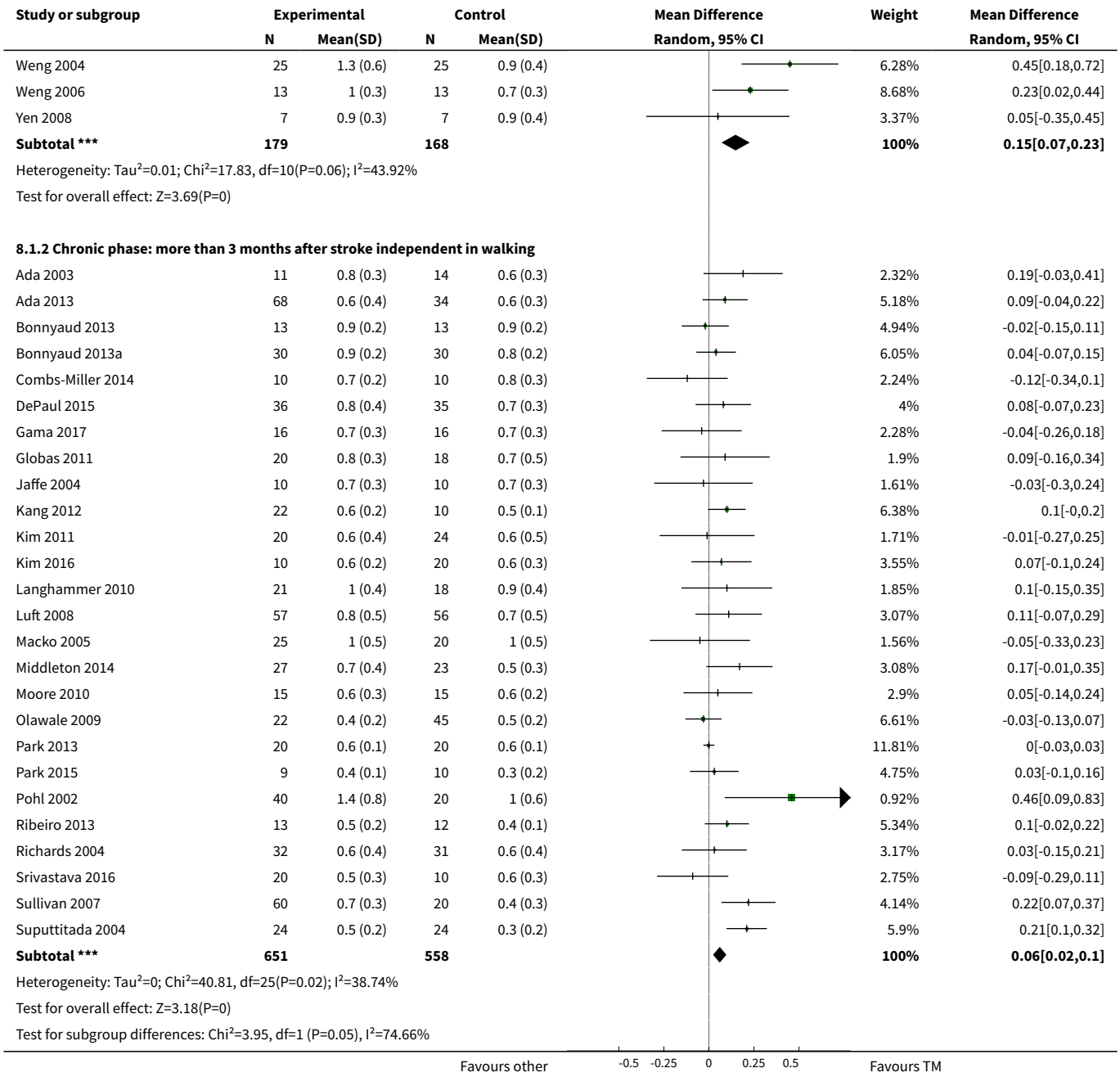


Comparison 8. Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of illness (independent in walking only)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed (m/s) at end of treatment	37		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1 Acute phase: less then or equal to 3 months after stroke independent in walking	11	347	Mean Difference (IV, Random, 95% CI)	0.15 [0.07, 0.23]
1.2 Chronic phase: more than 3 months after stroke independent in walking	26	1209	Mean Difference (IV, Random, 95% CI)	0.06 [0.02, 0.10]
2 Walking endurance (m) at end of treatment	23		Mean Difference (IV, Random, 95% CI)	Subtotals only
2.1 Acute phase: less then or equal to 3 months after stroke independent in walking	5	178	Mean Difference (IV, Random, 95% CI)	48.64 [23.97, 73.32]
2.2 Chronic phase: more than 3 months after stroke independent in walking	18	863	Mean Difference (IV, Random, 95% CI)	10.69 [-0.28, 21.66]

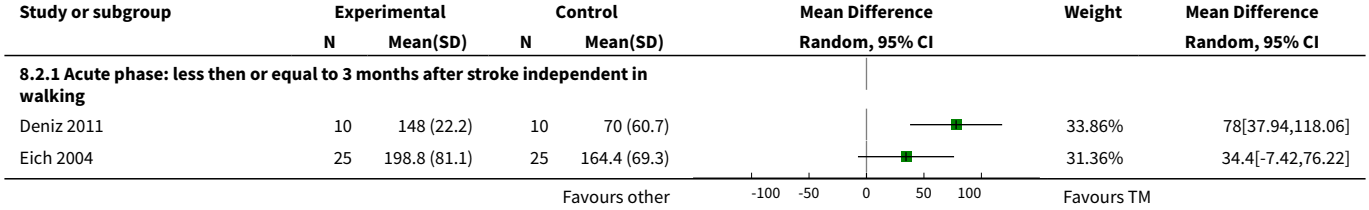
Analysis 8.1. Comparison 8 Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of illness (independent in walking only), Outcome 1 Walking speed (m/s) at end of treatment.



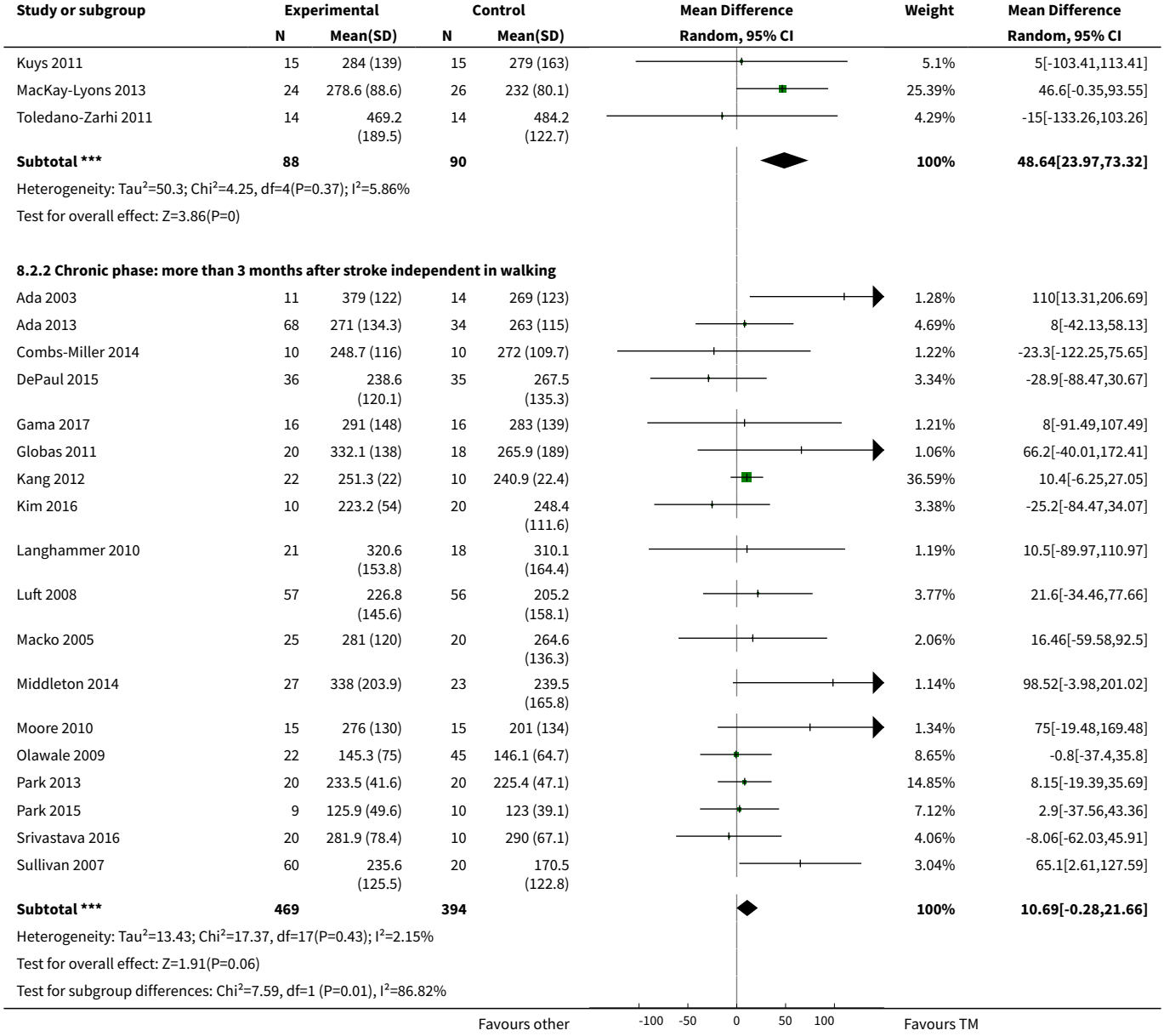


Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
Weng 2004	25	1.3 (0.6)	25	0.9 (0.4)		6.28%	0.45[0.18,0.72]
Weng 2006	13	1 (0.3)	13	0.7 (0.3)		8.68%	0.23[0.02,0.44]
Yen 2008	7	0.9 (0.3)	7	0.9 (0.4)		3.37%	0.05[-0.35,0.45]
Subtotal ***	**179**		**168**			**100%**	**0.15[0.07,0.23]**
Heterogeneity: Tau²=0.01; Chi²=17.83, df=10(P=0.06); I²=43.92%							
Test for overall effect: Z=3.69(P=0)							
8.1.2 Chronic phase: more than 3 months after stroke independent in walking							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		2.32%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		5.18%	0.09[-0.04,0.22]
Bonnyaud 2013	13	0.9 (0.2)	13	0.9 (0.2)		4.94%	-0.02[-0.15,0.11]
Bonnyaud 2013a	30	0.9 (0.2)	30	0.8 (0.2)		6.05%	0.04[-0.07,0.15]
Combs-Miller 2014	10	0.7 (0.2)	10	0.8 (0.3)		2.24%	-0.12[-0.34,0.1]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		4%	0.08[-0.07,0.23]
Gama 2017	16	0.7 (0.3)	16	0.7 (0.3)		2.28%	-0.04[-0.26,0.18]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		1.9%	0.09[-0.16,0.34]
Jaffe 2004	10	0.7 (0.3)	10	0.7 (0.3)		1.61%	-0.03[-0.3,0.24]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		6.38%	0.1[-0,0.2]
Kim 2011	20	0.6 (0.4)	24	0.6 (0.5)		1.71%	-0.01[-0.27,0.25]
Kim 2016	10	0.6 (0.2)	20	0.6 (0.3)		3.55%	0.07[-0.1,0.24]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		1.85%	0.1[-0.15,0.35]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		3.07%	0.11[-0.07,0.29]
Macko 2005	25	1 (0.5)	20	1 (0.5)		1.56%	-0.05[-0.33,0.23]
Middleton 2014	27	0.7 (0.4)	23	0.5 (0.3)		3.08%	0.17[-0.01,0.35]
Moore 2010	15	0.6 (0.3)	15	0.6 (0.2)		2.9%	0.05[-0.14,0.24]
Olawale 2009	22	0.4 (0.2)	45	0.5 (0.2)		6.61%	-0.03[-0.13,0.07]
Park 2013	20	0.6 (0.1)	20	0.6 (0.1)		11.81%	0[-0.03,0.03]
Park 2015	9	0.4 (0.1)	10	0.3 (0.2)		4.75%	0.03[-0.1,0.16]
Pohl 2002	40	1.4 (0.8)	20	1 (0.6)		0.92%	0.46[0.09,0.83]
Ribeiro 2013	13	0.5 (0.2)	12	0.4 (0.1)		5.34%	0.1[-0.02,0.22]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		3.17%	0.03[-0.15,0.21]
Srivastava 2016	20	0.5 (0.3)	10	0.6 (0.3)		2.75%	-0.09[-0.29,0.11]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		4.14%	0.22[0.07,0.37]
Suputtitada 2004	24	0.5 (0.2)	24	0.3 (0.2)		5.9%	0.21[0.1,0.32]
Subtotal ***	**651**		**558**			**100%**	**0.06[0.02,0.1]**
Heterogeneity: Tau²=0; Chi²=40.81, df=25(P=0.02); I²=38.74%							
Test for overall effect: Z=3.18(P=0)							
Test for subgroup differences: Chi²=3.95, df=1 (P=0.05), I²=74.66%							

Analysis 8.2. Comparison 8 Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of illness (independent in walking only), Outcome 2 Walking endurance (m) at end of treatment.



Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
8.2.1 Acute phase: less then or equal to 3 months after stroke independent in walking							
Deniz 2011	10	148 (22.2)	10	70 (60.7)		33.86%	78[37.94,118.06]
Eich 2004	25	198.8 (81.1)	25	164.4 (69.3)		31.36%	34.4[-7.42,76.22]



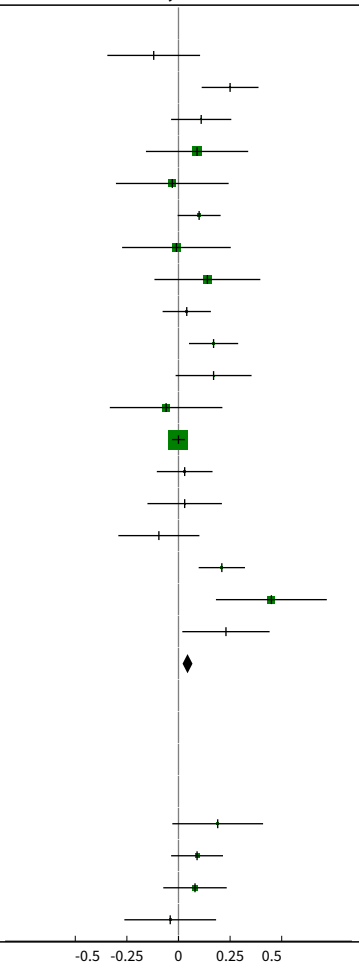
Comparison 9. Subgroup analysis: treadmill (with or without body weight support) versus other, by intensity (frequency) of training (independent in walking only)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed (m/s) at end of treatment	38		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.1 treadmill training 5 times a week or more	19	671	Mean Difference (IV, Fixed, 95% CI)	0.04 [0.02, 0.07]
1.2 treadmill training 3 to 4 times a week	16	784	Mean Difference (IV, Fixed, 95% CI)	0.08 [0.03, 0.12]

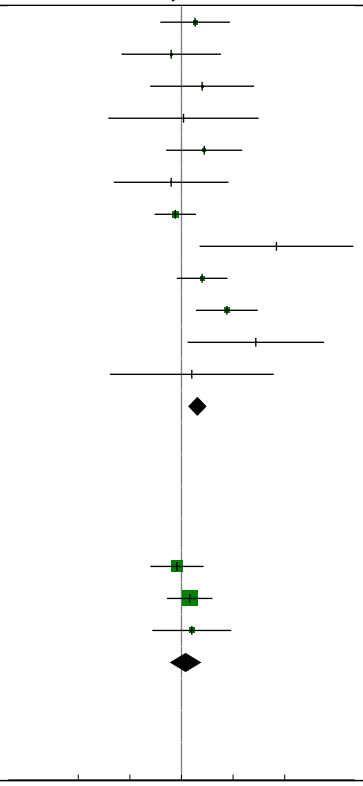
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1.3 treadmill training less then 3 times a week or unclear frequency	3	116	Mean Difference (IV, Fixed, 95% CI)	0.02 [-0.06, 0.10]
2 Walking endurance (m) at end of treatment	23		Mean Difference (IV, Random, 95% CI)	Subtotals only
2.1 treadmill training 5 times a week	9	392	Mean Difference (IV, Random, 95% CI)	27.25 [5.37, 49.13]
2.2 treadmill training 3 to 4 times a week	13	621	Mean Difference (IV, Random, 95% CI)	12.41 [-3.15, 27.97]
2.3 treadmill training less then 3 times a week or unclear	1	28	Mean Difference (IV, Random, 95% CI)	-15.0 [-133.26, 103.26]

Analysis 9.1. Comparison 9 Subgroup analysis: treadmill (with or without body weight support) versus other, by intensity (frequency) of training (independent in walking only), Outcome 1 Walking speed (m/s) at end of treatment.

Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Fixed, 95% CI	Weight	Mean Difference Fixed, 95% CI
9.1.1 treadmill training 5 times a week or more							
Combs-Miller 2014	10	0.7 (0.2)	10	0.8 (0.3)		1.15%	-0.12[-0.34,0.1]
Deniz 2011	10	0.5 (0.2)	10	0.2 (0.1)		3.06%	0.25[0.11,0.39]
Eich 2004	25	0.7 (0.3)	25	0.6 (0.2)		2.72%	0.11[-0.04,0.26]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		0.94%	0.09[-0.16,0.34]
Jaffe 2004	10	0.7 (0.3)	10	0.7 (0.3)		0.78%	-0.03[-0.3,0.24]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		5.35%	0.1[-0,0.2]
Kim 2011	20	0.6 (0.4)	24	0.6 (0.5)		0.84%	-0.01[-0.27,0.25]
Laufer 2001	13	0.5 (0.4)	12	0.3 (0.2)		0.88%	0.14[-0.12,0.4]
MacKay-Lyons 2013	24	0.8 (0.2)	26	0.7 (0.2)		4.24%	0.04[-0.08,0.16]
Mao 2015	15	0.5 (0.2)	14	0.3 (0.1)		4.08%	0.17[0.05,0.29]
Middleton 2014	27	0.7 (0.4)	23	0.5 (0.3)		1.71%	0.17[-0.01,0.35]
Nilsson 2001b	8	0.8 (0.3)	9	0.8 (0.3)		0.78%	-0.06[-0.33,0.21]
Park 2013	20	0.6 (0.1)	20	0.6 (0.1)		60.3%	0[-0.03,0.03]
Park 2015	9	0.4 (0.1)	10	0.3 (0.2)		3.18%	0.03[-0.1,0.16]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		1.78%	0.03[-0.15,0.21]
Srivastava 2016	20	0.5 (0.3)	10	0.6 (0.3)		1.5%	-0.1[-0.29,0.1]
Suputtitada 2004	24	0.5 (0.2)	24	0.3 (0.2)		4.61%	0.21[0.1,0.32]
Weng 2004	25	1.3 (0.6)	25	0.9 (0.4)		0.8%	0.45[0.18,0.72]
Weng 2006	13	1 (0.3)	13	0.7 (0.3)		1.3%	0.23[0.02,0.44]
Subtotal ***	**347**		**324**			**100%**	**0.04[0.02,0.07]**
Heterogeneity: Tau²=0; Chi²=50.25, df=18(P<0.0001); I²=64.18%							
Test for overall effect: Z=3.57(P=0)							
9.1.2 treadmill training 3 to 4 times a week							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		4.16%	0.19[-0.03,0.41]
Ada 2013	68	0.6 (0.3)	34	0.6 (0.3)		12.73%	0.09[-0.04,0.22]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		8.5%	0.08[-0.07,0.23]
Gama 2017	16	0.7 (0.3)	16	0.7 (0.3)		4.07%	-0.04[-0.26,0.18]

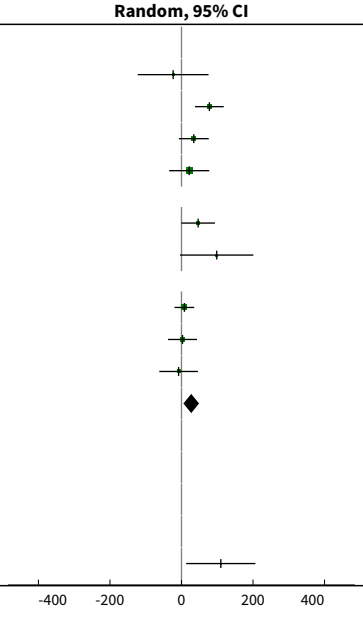


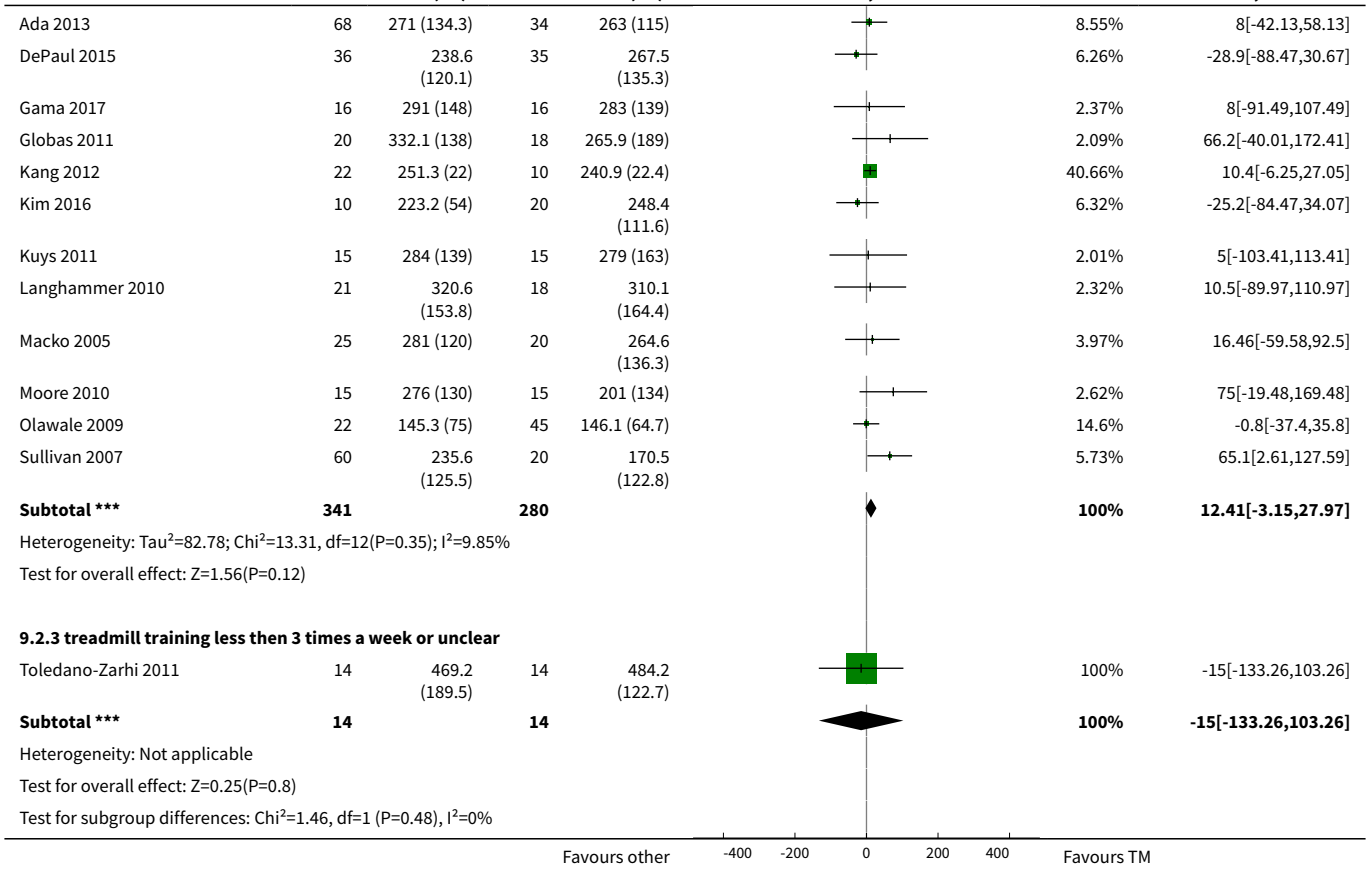
Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Fixed, 95% CI	Weight	Mean Difference Fixed, 95% CI
Kim 2016	10	0.6 (0.2)	20	0.6 (0.3)		7.08%	0.07[-0.1,0.23]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		3.46%	-0.05[-0.29,0.19]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		3.17%	0.1[-0.15,0.35]
Liston 2000	7	0.7 (0.3)	8	0.7 (0.4)		1.51%	0.01[-0.35,0.37]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		5.91%	0.11[-0.07,0.29]
Macko 2005	25	1 (0.5)	20	1 (0.5)		2.6%	-0.05[-0.33,0.23]
Olawale 2009	22	0.4 (0.2)	45	0.5 (0.2)		19.95%	-0.03[-0.13,0.07]
Pohl 2002	40	1.4 (0.8)	20	1 (0.6)		1.45%	0.46[0.09,0.83]
Ribeiro 2013	13	0.5 (0.2)	12	0.4 (0.1)		13.37%	0.1[-0.02,0.22]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		8.94%	0.22[0.07,0.37]
Takami 2010	24	1.5 (0.5)	12	1.1 (0.5)		1.84%	0.36[0.03,0.69]
Yen 2008	7	0.9 (0.3)	7	0.9 (0.4)		1.27%	0.05[-0.35,0.45]
Subtotal ***	**432**		**352**			**100%**	**0.08[0.03,0.12]**
Heterogeneity: Tau²=0; Chi²=19.19, df=15(P=0.21); I²=21.85%							
Test for overall effect: Z=3.37(P=0)							
9.1.3 treadmill training less then 3 times a week or unclear frequency							
Bonnyaud 2013	13	0.9 (0.2)	13	0.9 (0.2)		35.26%	-0.02[-0.15,0.11]
Bonnyaud 2013a	30	0.9 (0.2)	30	0.8 (0.2)		48.66%	0.04[-0.07,0.15]
Moore 2010	15	0.6 (0.3)	15	0.6 (0.2)		16.07%	0.05[-0.14,0.24]
Subtotal ***	**58**		**58**			**100%**	**0.02[-0.06,0.1]**
Heterogeneity: Tau²=0; Chi²=0.63, df=2(P=0.73); I²=0%							
Test for overall effect: Z=0.5(P=0.61)							
Test for subgroup differences: Chi²=2.23, df=1 (P=0.33), I²=10.49%							



Analysis 9.2. Comparison 9 Subgroup analysis: treadmill (with or without body weight support) versus other, by intensity (frequency) of training (independent in walking only), Outcome 2 Walking endurance (m) at end of treatment.

Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
9.2.1 treadmill training 5 times a week							
Combs-Miller 2014	10	248.7 (116)	10	272 (109.7)		4.13%	-23.3[-122.25,75.65]
Deniz 2011	10	148 (22.2)	10	70 (60.7)		14.06%	78[37.94,118.06]
Eich 2004	25	198.8 (81.1)	25	164.4 (69.3)		13.49%	34.4[-7.42,76.22]
Luft 2008	57	226.8 (145.6)	56	205.2 (158.1)		9.68%	21.6[-34.46,77.66]
MacKay-Lyons 2013	24	278.6 (88.6)	26	232 (80.1)		11.95%	46.6[-0.35,93.55]
Middleton 2014	27	338 (203.9)	23	239.5 (165.8)		3.89%	98.52[-3.98,201.02]
Park 2013	20	233.5 (41.6)	20	225.4 (47.1)		18.71%	8.15[-19.39,35.69]
Park 2015	9	125.9 (49.6)	10	123 (39.1)		13.93%	2.9[-37.56,43.36]
Srivastava 2016	20	281.9 (78.4)	10	290 (67.1)		10.16%	-8.06[-62.03,45.91]
Subtotal ***	**202**		**190**			**100%**	**27.25[5.37,49.13]**
Heterogeneity: Tau²=468.47; Chi²=14.66, df=8(P=0.07); I²=45.42%							
Test for overall effect: Z=2.44(P=0.01)							
9.2.2 treadmill training 3 to 4 times a week							
Ada 2003	11	379 (122)	14	269 (123)		2.5%	110[13.31,206.69]





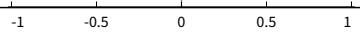
Comparison 10. Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of training period (independent in walking only)

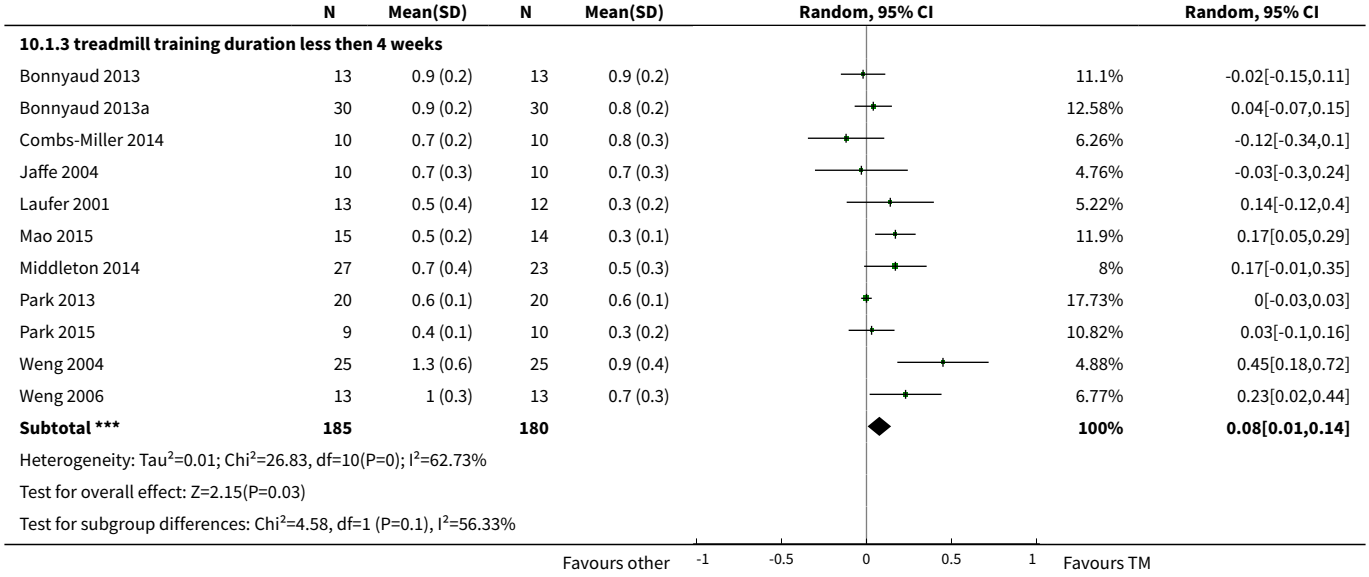
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Walking speed (m/s) at end of treatment	38		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1 treadmill training duration more than 4 weeks	14	802	Mean Difference (IV, Random, 95% CI)	0.05 [0.01, 0.09]
1.2 treadmill training duration 4 weeks	13	404	Mean Difference (IV, Random, 95% CI)	0.13 [0.07, 0.19]
1.3 treadmill training duration less then 4 weeks	11	365	Mean Difference (IV, Random, 95% CI)	0.08 [0.01, 0.14]
2 Walking endurance (m) at end of treatment	23		Mean Difference (IV, Random, 95% CI)	Subtotals only
2.1 treadmill training duration more than 4 weeks	12	706	Mean Difference (IV, Random, 95% CI)	19.09 [2.29, 35.88]

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
2.2 treadmill training duration 4 weeks	7	206	Mean Difference (IV, Random, 95% CI)	29.40 [-4.75, 63.54]
2.3 treadmill training duration less then 4 weeks	4	129	Mean Difference (IV, Random, 95% CI)	9.82 [-15.48, 35.13]

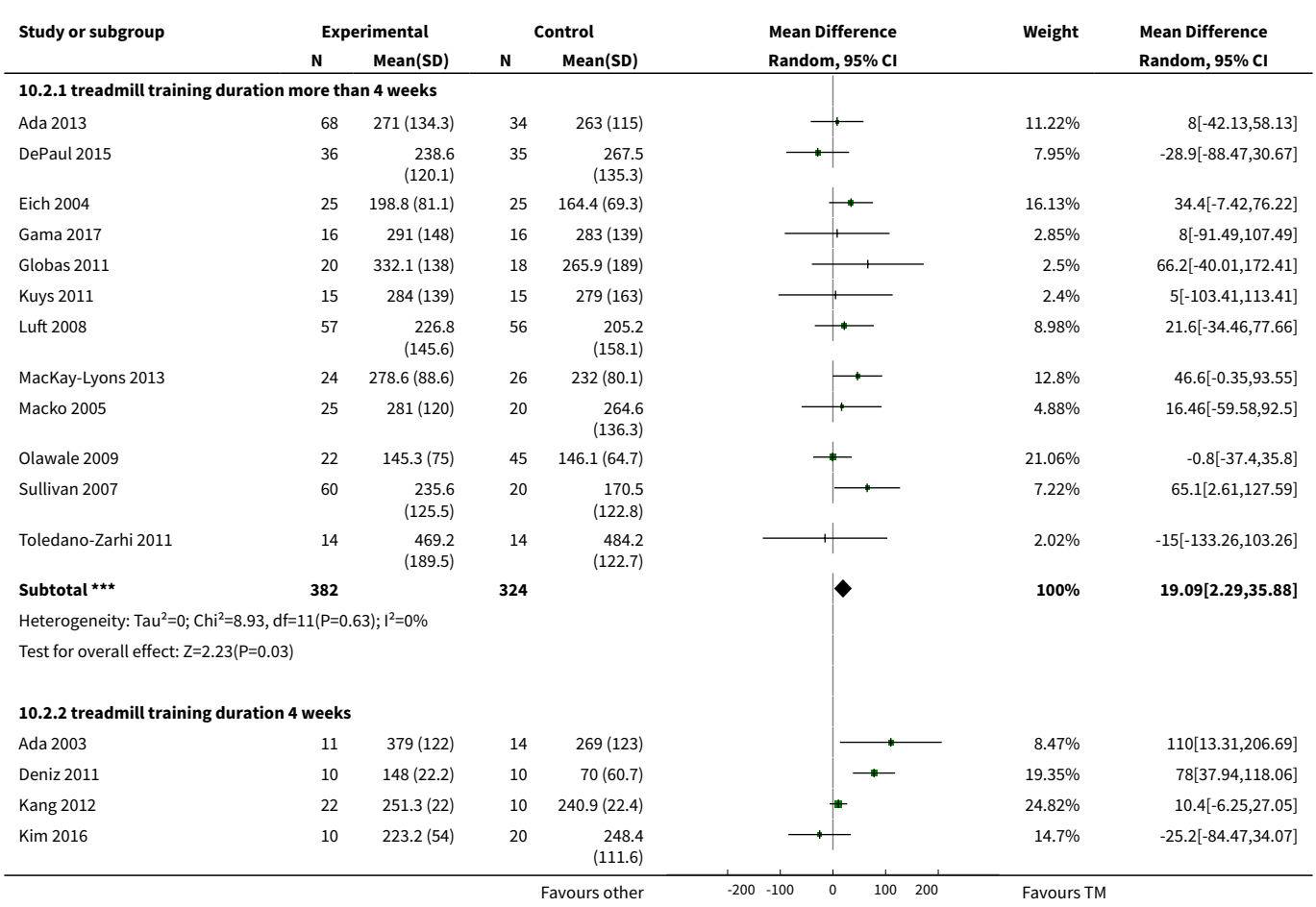
Analysis 10.1. Comparison 10 Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of training period (independent in walking only), Outcome 1 Walking speed (m/s) at end of treatment.

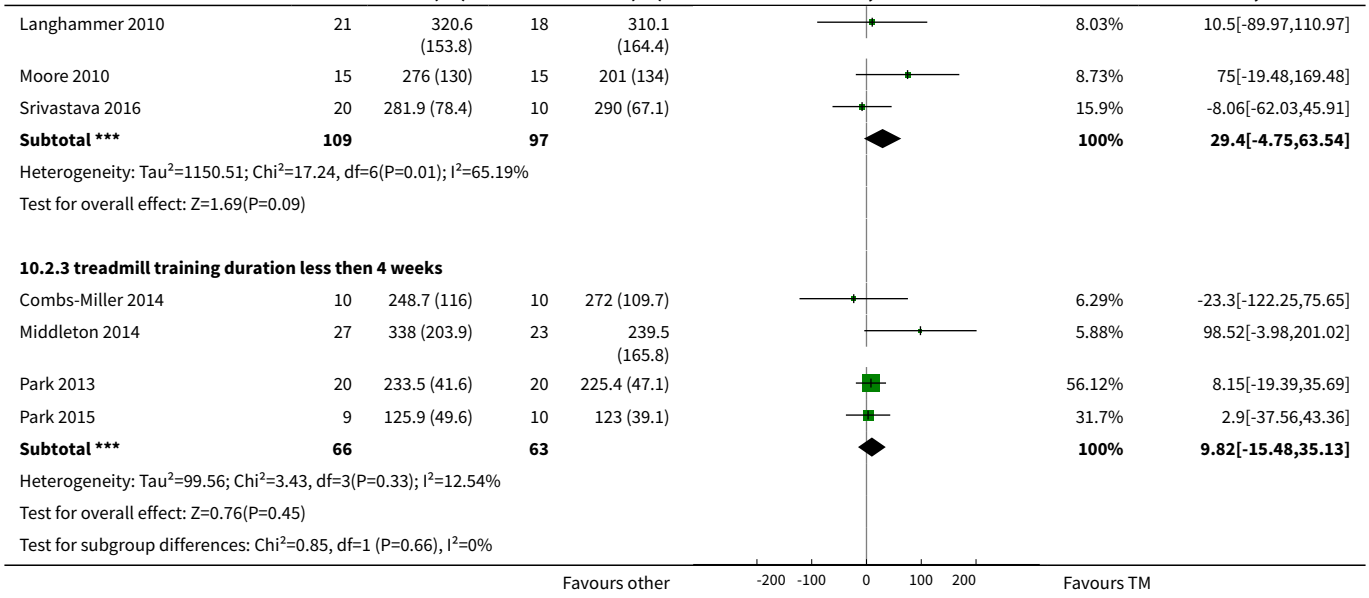
Study or subgroup	Experimental N	Experimental Mean(SD)	Control N	Control Mean(SD)	Mean Difference Random, 95% CI	Weight	Mean Difference Random, 95% CI
10.1.1 treadmill training duration more than 4 weeks							
Ada 2013	68	0.6 (0.4)	34	0.6 (0.3)		12.08%	0.09[-0.04,0.22]
DePaul 2015	36	0.8 (0.4)	35	0.7 (0.3)		8.07%	0.08[-0.07,0.23]
Eich 2004	25	0.7 (0.3)	25	0.6 (0.2)		8.96%	0.11[-0.04,0.26]
Gama 2017	16	0.7 (0.3)	16	0.7 (0.3)		3.86%	-0.04[-0.26,0.18]
Globas 2011	20	0.8 (0.3)	18	0.7 (0.5)		3.11%	0.09[-0.16,0.34]
Kim 2011	20	0.6 (0.4)	24	0.6 (0.5)		2.75%	-0.01[-0.27,0.25]
Kuys 2011	15	0.6 (0.3)	15	0.7 (0.4)		3.28%	-0.05[-0.29,0.19]
Luft 2008	57	0.8 (0.5)	56	0.7 (0.5)		5.61%	0.11[-0.07,0.29]
MacKay-Lyons 2013	24	0.8 (0.2)	26	0.7 (0.2)		13.96%	0.04[-0.08,0.16]
Macko 2005	25	1 (0.5)	20	1 (0.5)		2.47%	-0.05[-0.33,0.23]
Nilsson 2001b	8	0.8 (0.3)	9	0.8 (0.3)		2.56%	-0.06[-0.33,0.21]
Olawale 2009	22	0.4 (0.2)	45	0.5 (0.2)		18.94%	-0.03[-0.13,0.07]
Richards 2004	32	0.6 (0.4)	31	0.6 (0.4)		5.86%	0.03[-0.15,0.21]
Sullivan 2007	60	0.7 (0.3)	20	0.4 (0.3)		8.49%	0.22[0.07,0.37]
Subtotal ***	**428**		**374**			**100%**	**0.05[0.01,0.09]**
Heterogeneity: Tau^2=0; Chi^2=11.77, df=13(P=0.55); I^2=0%							
Test for overall effect: Z=2.26(P=0.02)							
10.1.2 treadmill training duration 4 weeks							
Ada 2003	11	0.8 (0.3)	14	0.6 (0.3)		6.08%	0.19[-0.03,0.41]
Deniz 2011	10	0.5 (0.2)	10	0.2 (0.1)		11.64%	0.25[0.11,0.39]
Kang 2012	22	0.6 (0.2)	10	0.5 (0.1)		15.58%	0.1[-0,0.2]
Kim 2016	10	0.6 (0.2)	20	0.6 (0.3)		9.11%	0.07[-0.1,0.24]
Langhammer 2010	21	1 (0.4)	18	0.9 (0.4)		4.88%	0.1[-0.15,0.35]
Liston 2000	7	0.7 (0.3)	8	0.7 (0.4)		2.56%	0.01[-0.35,0.37]
Moore 2010	15	0.6 (0.3)	15	0.6 (0.2)		7.51%	0.05[-0.14,0.24]
Pohl 2002	40	1.4 (0.8)	20	1 (0.6)		2.46%	0.46[0.09,0.83]
Ribeiro 2013	13	0.5 (0.2)	12	0.4 (0.1)		13.26%	0.1[-0.02,0.22]
Srivastava 2016	20	0.5 (0.3)	10	0.6 (0.3)		7.15%	-0.09[-0.29,0.11]
Suputtitada 2004	24	0.5 (0.2)	24	0.3 (0.2)		14.53%	0.21[0.1,0.32]
Takami 2010	24	1.5 (0.5)	12	1.1 (0.5)		3.05%	0.36[0.03,0.69]
Yen 2008	7	0.9 (0.3)	7	0.9 (0.4)		2.19%	0.05[-0.35,0.45]
Subtotal ***	**224**		**180**			**100%**	**0.13[0.07,0.19]**
Heterogeneity: Tau^2=0; Chi^2=17.12, df=12(P=0.15); I^2=29.89%							
Test for overall effect: Z=4.24(P<0.0001)							





Analysis 10.2. Comparison 10 Subgroup analysis: treadmill (with or without body weight support) versus other, by duration of training period (independent in walking only), Outcome 2 Walking endurance (m) at end of treatment.





ADDITIONAL TABLES

Table 1. Participant characteristics

Study ID	EXP age	CTL age	EXP gender	CTL gender	EXP time post-stroke	CTL time post-stroke	EXP paresis side	CTL paresis side
Ada 2003	Mean 66 (SD 11) years (excluding 1 dropout)	Mean 66 (SD 11) years (excluding 1 dropout)	Men/women 9/4	Men/women 10/4	Mean 28 (SD 17) months	Mean 26 (SD 20) months	Left/right 5/8	Left/right 8/6
Ada 2010	Mean 70 (SD 9) years	Mean 71 (SD 9) years	Men/women 38/26	Men/women 33/29	Mean 18 (SD 8) days	Mean 18 (SD 7) days	Left/right 34/30	Left/right 36/26
Ada 2013	Mean 67 (SD 12) years	Mean 63 (SD 13) years	Men/women 52/16	Men/women 19/15	Mean 21 (SD 16) months	Mean 19 (SD 13) months	Left/right 32/34	Left/right 13/21
Bonnyaud 2013	Mean 50 (SD 13) years (including both groups)		Men/women 45/15 (including both groups)		Mean 6 (SD 6) years (including both groups)		Left/right 30/30 (including both groups)	
Bonnyaud 2013a	Mean 50 (SD 13) years (including both groups)		Men/women 45/15 (including both groups)		Mean 6 (SD 6) years (including both groups)		Left/right 30/30 (including both groups)	
Combs-Miller 2014	Mean 45 (SD 21) years	Mean 48 (SD 10) years	Men/women 8/4	Men/women 10/3	Mean 6 (SD 6) years	Mean 5 (SD 4) years	Left/right 8/4	Left/right 8/5
	Mean 56 (SD 8) years	Mean 64 (SD 6) years	Men/women 4/6	Men/women 7/3	Mean 62 (SD 49) months	Mean 60 (SD 52) months	Left/right 6/4	Left/right 6/4
Da Cunha Filho 2002	Mean 57.8 (SD 5.5) years (excluding dropouts)	Mean 58.9 (SD 12.9) years (excluding dropouts)	Men/women 6/0	Men/women 7/0	Mean 15.7 (SD 7.7) days	Mean 19.0 (SD 12.7) days	Left/right/bilateral 1/4/1	Left/right 4/3
Deniz 2011	Mean 61.5 (SD 4.7) years	Mean 61.5 (SD 12.5) years	Men/women 8/2	Men/women 3/7	Mean 71 (SD 40) days	Mean 81 (SD 47) months	Left/right 6/4	Left/right 3/7
DePaul 2015	Mean 62 (SD 13) years	Mean 61.5 (SD 4.7) years	Men/women 21/14	Men/women 22/14	Median 19 (Q1 7, Q2 34) weeks	Median 18 (Q1 10, Q3 30) weeks	Left/right/bilateral 20/12/3	Left/right/bilateral 17/18/1
Du 2006	56 (6) years	58 (6) years	Men/women 35/32	Men/women 30/31	< 3 months	< 3 months	Left/right 31/36	Left/right 29/32
Duncan 2011	Mean 62 (SD 12) years	Mean 63 (SD 13) years	Men/women 159/123	Men/women 65/61	Mean 64 (SD 9) days	Mean 63 (SD 8) days	Left/right 121/161	Left/right 61/65

Table 1. Participant characteristics *(Continued)*

Eich 2004	Mean 62.4 (SD 4.8) years (all participants)	Mean 64.0 (SD 6.0) years (all participants)	Men/women 17/8	Men/women 16/9	Mean 6.1 (SD 2.2) weeks	Mean 6.3 (SD 2.5) weeks	Left/right 14/11	Left/right 14/11
Franceschini 2009	Mean 66 (SD 12) years	Mean 71 (SD 12) years	Men/women 28/24	Men/women 22/23 (only 45 described)	Mean 17 (SD 10) days	Mean 14 (SD 7) days	Left/right 29/23	Left/right 15/30 (only 45 described)
Gama 2017	Mean 59 (SD 8) years	Mean 58 (SD 10) years	Men/women 7/7 (only 14 described)	Men/women 8/6 (only 14 described)	Mean 60 (SD 55) months	Mean 54 (SD 42) months	Left/right 9/5 (only 14 described)	Left/right 6/8 (only 14 described)
Gan 2012	Not described	Not described	Not described	Not described	Not described	Not described	Not described	Not described
Globas 2011	Mean 69 (SD 7) years	Mean 69 (SD 6) years	Men/women 14/4 (only 18 described)	Men/women 15/3 (only 18 described)	Mean 60 (SD 47) months	Mean 70 (SD 67) months	Left/right 4/14 (only 18 described)	Left/right 9/9 (only 18 described)
Hoyer 2012	Mean 52 (SD 13) years	Mean 52 (SD 6) years	Men/women 20/10	Men/women 18/12	Mean 99 (SD 39) days	Mean 96 (SD 42) days	Left/right 17/13	Left/right 17/13
Jaffe 2004	Mean 58.2 (SD 11.2) years (excluding dropouts)	Mean 63.2 (SD 8.3) years (excluding dropouts)	Men/women 5/5 (excluding dropouts)	Men/women 7/3 (excluding dropouts)	Mean 3.9 (SD 2.3) years (excluding dropouts)	Mean 3.6 (SD 2.6) years (excluding dropouts)	Left/right 6/4 (excluding dropouts)	Left/right 4/6 (excluding dropouts)
Kang 2012	Mean 56 (SD 7) years	Mean 56 (SD 8) years	Men/women 10/10 (excluding dropouts)	Men/women 6/4 (excluding dropouts)	Mean 14 (SD 4) months	Mean 15 (SD 7) months	Left/right 8/12 (excluding dropouts)	Left/right 5/5 (excluding dropouts)
Kim 2011	Mean 51 (SD 4) years	Mean 50 (SD 8) years	Men/women 11/9	Men/women 14/10	Mean 15 (SD 6) months	Mean 14 (SD 3) months	Left/right 8/12	Left/right 8/16
Kim 2016	Mean 56.20 (SD 7.56) years	Mean 52.00 (SD 7.27) years	Men/women 4/6	Men/women 5/5	Mean 7.5 (SD 4.4) months	Mean 13.3 (SD 16.1) months	Left/right 3/7	Left/right 4/6

Table 1. Participant characteristics *(Continued)*

Kosak 2000	Mean 74 (SEM 2) years (all participants)	Mean 70 (SEM 2) years	Men/women 13/9	Men/women 18/16	Mean 39 (SEM 3) days	Mean 40 (SEM 4) days	Left/right/bilateral 8/12/2	Left/right/bilateral 12/16/6
Kuys 2011	Mean 63 (SD 14) years	Mean 72 (SD 17) years	Men/women 8/7	Men/women 6/9	Mean 52 (SD 32) days (excluding dropouts)	Mean 49 (SD 30) days (excluding dropouts)	Left/right 6/9	Left/right 11/4
Langhammer 2010	Mean 74 (SD 13) years	Mean 75 (SD 10) years	Men/women 10/11	Men/women 6/12	Mean 419 (SD 1034) days	Mean 349 (SD 820) days	Left/right 15/6	Left/right 13/5
Laufer 2001	Mean 66.6 (SD 7.2) years (excluding dropouts)	Mean 69.3 (SD 8.1) years (excluding dropouts)	Men/women 7/6	Men/women 7/5	Mean 32.6 (SD 21.2) days	Mean 35.8 (SD 17.3) days	Left/right 5/8	Left/right 5/7
Liston 2000	Mean 79.1 (SD 6.8) years (all EXP and CTL participants)		Men/women 12/6		Not reported	Not reported	Not reported	Not reported
Luft 2008	Mean 64 (SD 10) years	Mean 63 (SD 9) years	Men/women 14/20 (excluding dropouts)	Men/women 19/18 (excluding dropouts)	Mean 55 months (excluding dropouts)	Mean 63 months (excluding dropouts)	Left/right 21/12 (excluding dropouts)	Left/right 13/21 (excluding dropouts)
MacKay-Lyons 2013	Mean 62 (SD 15) years	Mean 59 (SD 13) years	Men/women 15/9	Men/women 14/12	Mean 23 (SD 6) days	Mean 23 (SD 4) days	Left/right 16/8	Left/right 13/13
Macko 2005	Mean 63 (SD 10) years	Mean 64 (SD 8) years	Men/women 22/10	Men/women 21/8	Mean 35 (SD 29) months	Mean 39 (SD 59) months	Left/right 18/14	Left/right 13/16
Mao 2015	Mean 59.6 (SD 9.2) years	Mean 60.8 (SD 10.7) years	Men/women 10/5	Men/women 9/4	Mean 49 (SD 20) months	Mean 48 (SD 17) months	Left/right 6/9	Left/right 6/7
Mehrberg 2001	Not described	Not described	Not described	Not described	Not described	Not described	Not described	Not described
Middleton 2014	Mean 61.4 (SD 15.7) years	Mean 60.7 (SD 11.4) years	Men/women 14/9	Men/women 16/4	Mean 50.4 (SD 56.8) months	Mean 29 (SD 52) months	Left/right 8/15	Left/right 8/12
Moore 2010	Mean 50 (SD 15) years (EXP and CTL participants)		Men/women 14/6 (EXP and CTL)		Mean 13 (SD 8) months (EXP and CTL)		Left/right 16/4 (EXP and CTL)	

Table 1. Participant characteristics *(Continued)*

Nilsson 2001	Median 54 (range 24 to 67) years (all participants)	Median 56 (range 24 to 66) years	Men/women 20/16	Men/women 20/17	Median 22 (range 10 to 56) days	Median 17 (range 8 to 53) days	Left/right/bilateral 21/11/4	Left/right/bilateral 18/14/5
Olawale 2009	Mean 56.8 (SD 6.4) years	Mean 57.0 (SD 7.1) years	Men/women 12/8	Men/women 22/18	Mean 10.2 (SD 6.9) months	Mean 10.5 (SD 6.3) months	Left/right 12/8	Left/right 19/21
Park 2013	Mean 53 (SD 8) years	Mean 53 (SD 9) years	Men/women 12/8	Men/women 13/7	Mean 21 (SD 7) months	Mean 16 (SD 8) months	Left/right 12/9	Left/right 10/10
Park 2015	Mean 55 (SD 10) years	Mean 52 (SD 13) years	Men/women 4/5	Men/women 6/4	Mean 10 (SD 3) months	Mean 13 (SD 4) months	Left/right 3/6	Left/right 6/4
Pohl 2002	Mean 58.2 (SD 10.5) years for EXP 1 (excluding dropouts) Mean 57.1 (SD 13.9) years for EXP 2 (excluding dropouts)	Mean 61.6 (SD 10.6) years (excluding dropouts)	Men/women 16/4 for EXP 1 Men/women 14/6 for EXP 2	Men/women 13/7	Mean 16.2 (SD 16.4) weeks for EXP 1 Mean 16.8 (SD 20.5) weeks for EXP 2	Mean 16.1 (SD 18.5) weeks	Left/right 15/5 for EXP 1 Left/right 16/4 for EXP 2	Left/right 16/4
Ribeiro 2013	Mean 56 (SD 8) years (without dropouts)	Mean 58 (SD 9) years (without dropouts)	Not described	Not described	Mean 33 (SD 25) months	Mean 20 (SD 10) months	Not described	Not described
Richards 1993	Mean 69.6 (SD 7.4) years (all participants)	Mean 67.3 (SD 11.2) years (CTL 1)	Men/women 5/5	Men/women 2/6	Mean 8.3 (SD 1.4) days	Mean 8.8 (SD 1.5) days	Left/right 8/2	Left/right 2/6
Richards 2004	Mean 62.9 (SD 12) years	Mean 60.7 (SD 12) years	Men/women 22/10	Men/women 21/10	Mean 52.0 (SD 22) months	Mean 52.6 (SD 18) months	Left/right 15/17	Left/right 20/11
Scheidtmann 1999	Mean 57.7 (SD 11.0) years (all participants)		Men/women 16/14		Mean 52.2 (SD 29.6) days		Left/right 17/13	
Smith 2008	Mean 57.8 (SD 7.0) years	Mean 56.0 (SD 8.3) years	Men/women 8/2	Men/women 4/6	< 1 year: 8 1 > 2 years: 2	< 1 year: 8 1 > 2 years: 2	Left/right 4/16	
Srivastava 2016	Mean group II 47.93 (SD 9.95) years; group III 44.20 (SD 11.70) years	Mean 44.40 (SD 12.31) years	Men/women group II 12/3; group III 12/3	Men/women 12/3	Mean group II 442.07 (SD 295.13) days; group III 391.80 (SD 431.10) days	mean 652.20 (SD 579.04) days	left/right group II 6/9; group III 8/7	Left/right 7/8

Table 1. Participant characteristics *(Continued)*

Sullivan 2007	Mean 60.0 (SD 13.3) years	Mean 63.4 (SD 8.4) years	Men/women 34/26	Men/women 11/9	Mean 23.8 (SD 15.2) months	Mean 28.4 (SD 19.0) months	Left/right 28/32	Left/right 10/10
Suputtitada 2004	Mean 61.1 (SD 10.2) years	Mean 64.9 (SD 10.7) years	Men/women 20/4	Men/women 15/9	Mean 27.3 (SD 26.6) months	Mean 21.6 (SD 27.7) months	Left/right 9/15	Left/right 8/16
Takami 2010	Mean 68.6 (SD 8.9) years	Mean 66.9 (SD 10.6) years	Men/women 15/9	Men/women 7/7	Mean 14.0 (SD 8.1) days	Mean 13.7 (SD 8.9) days	Left/right 12/12	Left/right 4/10
Toledano-Zarhi 2011	Mean 65 (SD 10) years	Mean 65 (SD 12) years	Men/women 11/3	Men/women 10/4	Mean 11 (SD 5) days	Mean 11 (SD 4) days	Not described	Not described
Visintin 1998	Mean 66.5 (SD 12.8) years (all participants)	Mean 66.7 (SD 10.1) years	Men/women 31/19	Men/women 28/22	Mean 68.1 (SD 26.5) days	Mean 78.4 (SD 30.0) days	Left/right 30/20	Left/right 21/29
Weng 2004	55.2 (15.4) years	54.6 (15.2) years	Men/women 17/6	Men/women 17/5	Mean 36.1 (SD 11.3) days	Mean 35.6 (SD 14.5) days	Left/right 10/13	Left/right 8/14
Weng 2006	51 (12) years	50 (14) years	Men/women 8/5	Men/women 9/4	Mean 62 (SD 24) days	Mean 63 (SD 34) days	Left/right 6/7	Left/right 7/6
Werner 2002a	Mean 59.7 (SD 10.2) years (all participants)	Mean 60.3 (SD 8.6) years (all participants)	Men/women 8/7	Men/women 5/10	Mean 7.4 (SD 2.0) weeks	Mean 6.9 (SD 2.1) weeks	Left/right 7/8	Left/right 7/8
Yang 2010	Mean 57.2 (SD 9.3) years	Mean 55.0 (SD 10.1) years	Men/women 5/5	Men/women 5/3	Mean 1.2 (SD 1.1) years	Mean 1.6 (SD 1.5) years	Left/right 5/5	Left/right 4/4
Yen 2008	Mean 57.3 (SD 16.4) years	Mean 56.1 (SD 12.7) years	Men/women 3/4	Men/women 6/1	Mean 2.0 (SD 0.6) months	Mean 2.0 (SD 2.4) months	Left/right 5/2	Left/right 3/4
Zhang 2008	63.3 (13.4) years	62.8 (15.4) years	Men/women 12/7	Men/women 13/7	68.7 (25.6) days	66.3 (23.3) days	Left/right 7/12	Left/right 8/12
Zhu 2004	56.9 (12.9) years	57.8 (12.16) years	Men/women 6/4	Men/women 7/3	Mean 4.1 (SD 4.8) months	Mean 3.1 (SD 4.2) months	Not stated by the authors	Not stated by the authors

CTL: control
EXP: experimental
Q1: first quartile (descriptive statistics)
Q2: second quartile
Q3: third quartile

SD: standard deviation
SEM: standard error of the mean

Table 2. Dose of experimental interventions

Study ID	EXP: treadmill	EXP: support	EXP: duration	EXP: frequency	EXP: N weeks	CTL: interventions	CTL: duration	CTL: frequency	CTL: N weeks
Ada 2003	Gradually increased on an individual basis starting from 0.7 m/s at the start of the first session and finishing at 1.1 m/s at the end of the last session, on average	BWS: no Hand support: yes, use of hand rails if required Assistance from therapist: only if required, 2 participants needed slight help with stepping through for the first 2 weeks	30 minutes (24, 21, 18, and 15 minutes in treadmill training in the first, second, third and fourth training weeks, respectively)	3 times per week	4 weeks	Sham (task-orientated home program with an intensity insufficient to produce an effect, plus telephone follow-up once each week)	30 minutes	3 times per week (plus encouraged to walk every day)	4 weeks
Ada 2010	Initial speed of the treadmill was set so that the therapist had time to assist the leg to swing through while maintaining a reasonable step length. If a participant was too disabled to walk on a moving treadmill with the assistance of a therapist, then the participant walked on the spot. Once they attained a speed of 0.4 m/s without body weight support, they commenced 10 minutes of overground walking	BWS: yes Hand support: no Assistance from therapist: yes if required	30 minutes	5 times per week	Until they achieved independent walking or were discharged The experimental group participated in a total of 1336 sessions	Assisted overground walking. Aids such as knee splints, ankle–foot orthoses, parallel bars, forearm support frames and walking sticks could be used as part of the intervention. If a participant was too disabled to walk with the help of a therapist, then the participant practiced shifting weight and stepping forwards and backwards. Once participants	30 minutes	5 times per week	Until they achieved independent walking or were discharged. The experimental group participated in a total of 1490 sessions

Table 2. Dose of experimental interventions *(Continued)*

						could walk with assistance, they were instructed to increase their speed and assistance from both the therapist and aids was reduced			
Ada 2013	Treadmill was run at a comfortable speed and participants were instructed to "walk as slowly as possible" and/or a metronome was used to decrease cadence thereby encouraging larger steps. When necessary, marching-type steps were included to encourage hip and knee flexion during swing phase to improve toe clearance. When a normal step length was observed, the therapist increased the speed of the treadmill until step length was compromised. Workload was then progressed by increasing the incline of the treadmill. Overground walking was used each session and comprised 20% of intervention time in week 1 and was progressively increased each week so that it comprised 50% of the 30 minutes intervention time in week 8 of training. In week 9, the 4-month training group returned to 20% overground walking, which was again increased to 50% by week 16	BWS: no Hand support: no Assistance from therapist: no	30 minutes	3 times per week	Group 1: 16 weeks Group 2: eight weeks	Control group received no intervention.	-	-	-

Table 2. Dose of experimental interventions *(Continued)*

Bonnyaud 2013	Comfortable walking speed	No BWS	20 minutes	Single session	-	Overground gait-training with constant walking speed	20 minutes	Single session	-
Bonnyaud 2013a	1 EXP subgroup walking on treadmill without a mass , other EXP subgroup walking on treadmill with a mass. Participants were instructed to walk without stopping, at their own comfortable speed. The mass fixed to the ankle of the non-paretic lower limb was 2 kg for women and 4 kg for men	No BWS	20 minutes	Single session	-	1 CTL subgroup walking overground without a mass other CTL subgroup walking overground with a mass. Participants were instructed to walk without stopping, at their own comfortable speed. The mass fixed to the ankle of the non-paretic lower limb was 2 kg for women and 4 kg for men	20 minutes	Single session	-
Combs-Miller 2014	Body weight-supported treadmill training. Rest breaks were allowed as needed, however, breaks were not included in the overall walking time. Walking speed was increased or decreased based on the Borg rating of 11 to 14. Participants were instructed to achieve their fastest possible walking pace on the treadmill at every training session, without exceeding the moderate intensity level on the Borg scale.	BWS: began with 30% of total body weight unloaded. BWS was reduced to 15%, and then 0% after participants achieved a treadmill speed of at least 2.0 mph, required no more than two breaks during the 30-minute training session, and maintained optimal quality of gait for 5 minutes without assistance.	30 minutes	5 days per week	2 weeks	Overground walking training. Rest breaks were allowed as needed, however, breaks were not included in the overall walking time.	30 minutes	5 days per week	2 weeks

Table 2. Dose of experimental interventions *(Continued)*

Da Cunha Filho 2002	Gradually increased in increments of 0.01 m/s, starting at 0.01 m/s	BWS: yes, starting at 30% body weight and progressively decreased to 0% Hand support: not reported Assistance from therapist: not reported	20 minutes	5 times per week	2 to 3 weeks	Task-orientated gait-training	20 minutes	5 times per week	2 to 3 weeks
Deniz 2011	10-minute sessions, if necessary separated by 5-minute resting period, training at comfortable walking speed every 3 to 5 minutes was increased by increments of 0.01 m/s	BWS: yes Hand support: not reported Assistance from therapist: not reported	60 minutes	5 times per week	4 weeks	Range of motion, stretching, strengthening, balance, co-ordination exercises and conventional ambulation training treatment program with parallel bars	60 minutes	5 times per week	4 weeks
DePaul 2015	Treadmill training assisted by 1 or more physical therapy staff (physical guidance, at or above 0.89 m/s)	BWS: yes up to 40% of BWS, weaned according to performance Handle use discouraged	Up to 30 minutes	15 sessions	5 weeks	Motor learning Walking Programm (practising 7 core walking activities)	Up to 40 minutes	15 sessions	5 weeks
Du 2006	Gradually increased starting from 0.1 m/s to 0.5 m/s; interval method, resting period gradually reduced	BWS: yes, initial BWS 30% to 40% weight, gradual reduction Hand support: not reported Assistance from therapist: not reported	40 minutes	2 times per day	4 weeks	Brunnstrom, Bobath, Rood therapy approaches as well as proprioceptive neuromuscular facilitation techniques and motor relearning program, transfer training, trunk stabilisation	40 minutes	Unclear	4 weeks

Table 2. Dose of experimental interventions *(Continued)*

Duncan 2011	At 0.89 m/s, followed by a progressive program of walking overground for 15 minutes. The treadmill speeds ranged from 0 to 1.6 km per hour, increasing by increments of 0.16 km per hour.	BWS: yes Hand support: not reported Assistance from therapist: yes	90 minute sessions	3 times per week	12 to 16 weeks (30 and 36 exercise sessions within this period)	Home exercise as an active control, not as a high-intensity, task-specific walking program. Progression through the program was managed by a physical therapist in the home, with the goals of enhancing flexibility, range of motion in joints, strength of arms and legs, co-ordination, and static and dynamic balance. Participants in this program were encouraged to walk daily.	90-minute sessions	3 times per week	12 to 16 weeks (30 and 36 exercise sessions within this period)
Eich 2004	Speed and inclination increased on an individual basis to achieve a training heart rate. Mean speed increased from 0.35 m/s (SD 0.11) in week 1 to 0.64 m/s (SD 0.15) in week 6. In week 1, only 1/25 participants had an inclination of 4 degrees; this increased to 25/25 participants in week 6, with a mean inclination of 6.2 degrees.	BWS: yes, the harness was always secured and body weight was minimally supported (0 to 15%) according to participant needs. Hand support: not reported Assistance from therapist: yes, to set the paretic leg, weight shift and hip extension, if required	30 minutes	5 times per week	6 weeks	Not task-orientated (neurophysiological)	30 minutes	5 times per week	6 weeks
Franceschini 2009	Speed starting from 0.1 m/s and aiming at 1.2 m/s according to the participant's	BWS: yes, limited to 40% of body weight, gradually reduced	20 minutes + 40 minutes	2 times per day	20 sessions within 5 weeks	20 sessions of overground gait-	60 minutes	5 times per week	20 sessions within 5 weeks

Table 2. Dose of experimental interventions *(Continued)*

	compliance and progress. Conventional treatment was performed for 40 minutes, not immediately after treadmill training.	Hand support: not reported Assistance from therapist: 2 trained physical therapists for each participant to control the paretic lower extremity and pelvis, when pelvic and paretic lower extremity control was considered adequate, training was administered by 1 physical therapist only.				training of 60 minutes each			
Gama 2017	Body weight support treadmill training and comfortable treadmill speed was set	BWS: yes, from 30% to 0% of body weight Hand support: allowed Assistance from therapist: allowed	45 minutes	3 times per week	6 weeks	Walking overground at comfortable walking speed	45 minutes	3 times per week	6 weeks
Gan 2012	Body weight support treadmill training; treadmill speed was initially started at 0.5 mph	BWS: yes, up to 40% of their body weight supported at the beginning of the training, gradually reduced Hand support: unclear Assistance from therapist: unclear	Not described	Not described	8 weeks	Body weight support overground ambulation training	Not described	Not described	8 weeks
Globas 2011	Beginning with 10 to 20 minutes) at 60% to 80% of the maximum heart rate reserve (starting with 40% to 50% HRR). Duration was in-	BWS: no Hand support: allowed Assistance from therapist: unclear	30 to 50 minutes	3 times per week	3 months (39 sessions)	Passive, muscle tone–regulating exercises for the upper and lower extremities with elements of	60 minutes	3 times per week	3 months (13 weeks)

Table 2. Dose of experimental interventions *(Continued)*

	creased as tolerated by 1 to 5 minutes per week Treadmill speed was progressed by 0.1 to 0.3 km/hour every 1 to 2 weeks Training was a group intervention (3 participants trained in parallel)	Treadmill inclination at 0°				balance training conducted on an outpatient basis in physiotherapy practices or rehabilitation centres. No aerobic fitness training was performed.			
Hoyer 2012	Treadmill therapy with BWS and on days without TTB-WS, conventional gait-training was conducted	BWS: yes Hand support: not reported Assistance from therapist: not reported	30 minutes	Daily for the first 4 weeks (20 sessions), and then 1 to 2 times a week (10 sessions) for the remaining 6 weeks	30 sessions for a period of a minimum of 10 weeks	Intensive gait-training (30 minutes) and functional training (30 minutes) daily for a minimum of 10 weeks	30 minutes	Daily	For a minimum of 10 weeks
Jaffe 2004	Comfortable walking speed (speed not reported), speed was not progressed	BWS: no, harness used to prevent falls only Hand support: yes, use of hand rails, if required Assistance from therapist: no	60 minutes	3 times per week	2 weeks	Task-orientated (overground obstacle training)	60 minutes	3 times per week	2 weeks
Kang 2012	Group 1: treadmill training with optic flow (optic flow was applied and treadmill speed was increased by 0.1 km/hour each time once the participant could walk stably for more than 20 seconds) Group 2: treadmill training without optic flow	BWS: no Hand support: allowed but discouraged Assistance from therapist: no	30 minutes (2 times for 15 minutes with a rest between)	3 times per week	4 weeks	General stretching with added range of motion exercises in the less and more affected sides of the trunk, arms and legs for the same time. Exercise therapy was performed using	30 minutes	3 times per week	4 weeks

Table 2. Dose of experimental interventions *(Continued)*

	(treadmill speed was increased by 0.1 km/hour each time once the participants could walk stably for more than 20 seconds)					the traditional motor development theory and neurodevelopmental treatment based on motor learning theory.			
Kim 2011	Gradually increased starting from 0.3 m/s to 0.7 m/s	BWS: no Hand support: no Assistance from therapist: no	30 minutes	5 times per week	6 weeks	Control group received muscle strengthening (seated leg press, knee extension, leg abductor)	30 minutes	5 times per week	6 weeks
Kim 2016	Treadmill training with virtual reality in addition to general physical therapy If the participant maintained the speed and felt safe for 20 s, the treadmill speed was then increased by 5% during next training session	BWS: no Hand support: unclear Assistance from therapist: unclear	30 minutes	3 times per week	4 weeks	2 control groups: 1 control group received community ambulation in addition to general physical therapy, the other control group no additional walking training to general physical therapy	30 minutes	3 times per week	4 weeks
Kosak 2000	Gradually increased from 0.22 to 0.89 m/s, as tolerated	BWS: yes, starting at 30% body weight and progressively decreased to 0% or eliminated Hand support: yes, use of hand rails, if required Assistance from therapist: yes, assisted with swing phase, foot placement and weight shift, if required	45 minutes	5 times per week	2 to 3 weeks	Not task-orientated (orthopaedic)	45 minutes	5 times per week	2 to 3 weeks

Table 2. Dose of experimental interventions *(Continued)*

Kuys 2011	Walked on the treadmill at an intensity of 40% to 60% heart rate reserve or a Borg Rating of Perceived Exertion of 11 to 14. Participants commenced at an intensity level of 40% heart rate reserve for 30 minutes, progressing each week aiming for a 5% to 10% increase until 60% heart rate reserve was reached. For participants unable to reach 40% heart rate reserve on commencement of treadmill walking, treadmill speeds were set as fast as tolerated and progressed as quickly as possible. Also received task-oriented physiotherapy, approximately 1 hour per day	BWS: no Hand support: yes, were encouraged to hold the handrail Assistance from therapist: yes, a physiotherapist provided assistance as required to ensure foot clearance during swing phase	30 minutes	3 times per week	6 weeks	Received usual physiotherapy intervention only	Unclear (probably the same as the EXP group)	Unclear (probably the same as the EXP group)	Unclear (probably the same as the EXP group)
Langhammer 2010	Walking speed was started on the lowest level and was increased within the first minutes to the working level. The working load was increased in co-operation with the participants to a level they felt comfortable with and they felt no insecurity in balance or discomfort otherwise.	BWS: no Hand support: yes Assistance from therapist: no, and no inclination	30 minutes	(Up to) 5 times per week	Mean of 16 days of inpatient stay (mean 10 walking sessions)	Outdoor walking at a comfortable speed and with the use of ordinary assistive devices, when necessary	30 minutes	(Up to) 5 times per week	Mean of 17 days of inpatient stay (mean 11 walking sessions)
Laufer 2001	Comfortable walking speed, speed used and progression not reported	BWS: no Hand support: yes, use of hand rails, if required Assistance from therapist: yes, assisted	8 to 20 minutes	5 times per week	3 weeks	Task-orientated	8 to 20 minutes	5 times per week	3 weeks

Table 2. Dose of experimental interventions *(Continued)*

		with swing phase and trunk alignment							
Liston 2000	Speed used and progression not reported	BWS: no Hand support: not reported Assistance from therapist: not reported	60 minutes	3 times per week	4 weeks	Task-orientated	60 minutes	3 times per week	4 weeks
Luft 2008	Aerobic intensity of 60% of heart rate reserve. Duration and intensity started low (10 to 20 minutes, 40% to 50% heart rate reserve) and increased approximately for 5 minutes and 5% heart rate reserve every 2 weeks, as tolerated. Treadmill velocity and incline were increased by 0.05 m/s and 1% increments, respectively	BWS: no Hand support: not reported Assistance from therapist: not reported	40 minutes	3 times per week	6 months	13 supervised traditional stretching movements on a raised mat table with a therapist's assistance. Each movement was performed actively if possible or passively with a therapist's assistance. Movements included quadriceps, calf, hip and hamstring stretch, low back rotation and stretch, chest stretch, bridging, shoulder shrug, abduction, and flexion, heel slides and short arc of quadriceps	40 minutes	3 times per week	6 month
MacKay-Lyons 2013	5 to 10 minutes of active/passive stretching exercises 10 to 15 minutes of upper extremity training (active exercises and strengthening)	BWS: yes 20% to 30% or 40%, if necessary of their body weight Hand support: handrail support was discouraged	40 minutes	5 times per week (after 6 weeks, 3 times per week)	6 weeks (plus 6 weeks; total of 48 sessions)	5 to 10 minutes of active/passive stretching exercises 10 to 15 minutes of upper extremity training (ac-	40 minutes	5 times per week (after 6 weeks, 3 times per week)	6 weeks (plus 6 weeks; total of 48 sessions)

Table 2. Dose of experimental interventions *(Continued)*

	10 to 15 minutes of lower extremity training (active exercises and strengthening) 25 to 30 minutes of BWSTT including warm-up and cool-down BWSTT initiated in 5 to 10-minute bouts at the heart rate achieved at 40% to 50% of baseline VO_2 peak. The goal was to achieve a target exercise duration (at least 20 minutes, exclusive of warm-up and cool-down) and intensity (heart rates corresponding to 60% to 75% of baseline VO_2 peak 27) by the fourth or fifth week. Initially, ambulatory-independent participants walked at a treadmill speed of 80% to 90% of their self-paced overground speed Ambulatory-dependent participants walked at a treadmill speed of 70% to 80% of their overground speed Treadmill speed and grade were gradually increased and percentage of manual and body weight support decreased, as tolerated	Assistance from therapist: therapist emphasised trunk and limb alignment, loading of the stance limb, hip extension at terminal stance, and advancement of the swing limb				tive exercises and strengthening) 10 to 15 minutes of lower extremity training (active exercises and strengthening) 25 to 30 minutes of overground gait-training			
Macko 2005	Increased from a mean of 0.48 (SE 0.30) m/s at baseline to 0.75 (SE 0.30) m/s at treatment end on an individual basis to achieve a target aerobic intensity of 60%	BWS: no Hand support: yes, use of handrails, if required	40 minutes (including 5 minutes warm-up and 5 min-	3 times per week	6 months	Task-orientated	40 minutes	3 times per week	6 months

Table 2. Dose of experimental interventions *(Continued)*

	to 70% heart rate reserve (treadmill slope increased from 0% at baseline to 2.2% (SE 2.2) at treatment end)	Assistance from therapist: not reported	utes cool-down) increased duration at target intensity from a mean of 12 (SE 6) minutes at baseline to 31 (SE 10) minutes at treatment end						
Mao 2015	Treadmill training, with gradually increased walking speed to 2.5 mph	BWS: yes, gradually decreased Hand support: unclear Assistance from therapist: yes	30 minutes	5 times per week	3 weeks	Individualised overground gait-training (based on the Bobath Approach)	30 minutes	5 times per week	3 weeks
Mehrberg 2001	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Middleton 2014	Treadmill training, with increasing walking speed	BWS: yes, from 8% to 50%, gradually decreased Hand support: unclear Assistance from therapist: no	60 minutes	5 times per week	10 days	Overground gait-training	60 minutes	5 times per week	10 days
Moore 2010	Intensive locomotor training with walking velocity increased in 0.5 km/h increments until participants' heart rate reached 80% to 85% of age-predicted maximum or until the partici-	BWS: up to 40% partial body weight support using a counterweight system attached to the	Unclear	2 to 5 times per week	4 weeks	Did not receive locomotor training or any other interventions	Unclear	2 to 5 times per week	4 weeks

Table 2. Dose of experimental interventions *(Continued)*

	pants' Rating of Perceived Exertion increased to 17 on the Borg scale, and was reduced in 10% increments, as tolerated	safety harness was provided for those participants who walked 0.2 m/s overground Hand support: handrail use for balance only Assistance from therapist: therapists did not provide manual assistance							
Nilsson 2001	Gradually increased from 0.0 to 2.0 m/s on an individual basis	BWS: yes, starting at 100% body weight and decreased to 0% Hand support: yes, use of a cross bar, if required Assistance from therapist: yes, assisted with swing phase, hip and knee extension during stance phase, and weight shift if required	30 minutes	5 times per week	9 to 10 weeks	Task-orientated	30 minutes	5 times per week	9 to 10 weeks
Olawale 2009	Participants walked on a treadmill at a "predetermined natural safe walking speed"	BWS: not reported Hand support: not reported Assistance from therapist: not reported	60 minutes of therapy, including 25 minutes treadmill training	3 times per week	12 weeks	Conventional physiotherapy, CTL 2 received overground gait-training included in the hourly therapy sessions, whereas CTL 1 received conventional physiotherapy only (active and passive range of motion exercises,	60 minutes	3 times per week	12 weeks

Table 2. Dose of experimental interventions *(Continued)*

						strength, and balance training)			
Park 2013	Treadmill gait-training at comfortable walking speed	BWS: not reported Hand support: not reported Assistance from therapist: not reported	30 minutes twice a day	5 times per week	1 week	Overground gait-training	30 minutes twice a day	5 times per week	1 week
Park 2015	Treadmill training with rhythmic auditory stimulation at convenient walking speed	BWS: not reported Hand support: not reported Assistance from therapist: not reported	30 minutes	5 times per week	3 weeks	Ground walking with rhythmic auditory stimulation	30 minutes	5 times per week	3 weeks
Pohl 2002	Speed-dependent treadmill training (EXP 1) - aggressive increase in speed starting from the highest speed the participant could walk at without stumbling and increasing at 10% increments of this speed several times within a session. The average treadmill speed increased from 0.68 m/s (SD 0.34) at the start of training to 2.05 m/s (SD 0.71) at the end of training; limited progressive treadmill training (EXP 2) - gradually increased in increments of 5% of the initial maximum walking speed each week. The average treadmill speed increased from 0.66 m/s (SD 0.39) at the start of training to 0.79 m/s (SD 0.47) at the end of training.	Speed-dependent treadmill training BWS: yes, no more than 10% body weight for the first 3 training sessions only (participants always wore an unweighted harness) Hand support: not reported Assistance from therapist: no Limited progressive treadmill training BWS: yes, no more than 10% body weight for the first 3 training sessions only Hand support: not reported	30 minutes	3 times per week	4 weeks	Not task-orientated (neurophysiological)	45 minutes	3 times per week	4 weeks

Table 2. Dose of experimental interventions *(Continued)*

		Assistance from therapist: yes, assisted with the walking cycle							
Ribeiro 2013	Treadmill training with partial body weight support at comfortable walking speed	BWS: yes, initially 30%, then decreased Hand support: not reported Assistance from therapist: yes, initially aided	30 minutes	3 times per week	4 weeks	Proprioceptive Neuromuscular Facilitation method (PNF, including waist dissociations, sitting and rising from a chair, antero-posterior and latero-lateral weight transfer)	30 minutes	3 times per week	4 weeks
Richards 1993	Speed used and progression not reported	BWS: no Hand support: not reported Assistance from therapist: not reported	105 minutes (about 35 minutes in treadmill training)	5 times per week	5 weeks	Not task-orientated (neurophysiological)	105 minutes	5 times per week	5 weeks
Richards 2004	Specialised locomotor training including tilt table, reciprocal stepping on a Kinetron device	BWS: no Hand support: not described Assistance from therapist: not described	60 minutes	5 times per week	8 weeks	Conventional physiotherapy (traditional neurodevelopmental approach, task-oriented motor learning, over-ground gait-training, stepping exercises)	60 minutes	5 times per week	8 weeks
Scheidtmann 1999	Gradually increased from 0.0 to 1.3m/s	BWS: yes, amount of body weight support and progression not reported Hand support: yes, use of hand rails, if required	30 minutes	5 times per week	3 weeks	Not task-orientated (neurophysiological)	30 minutes	5 times per week	3 weeks

Table 2. Dose of experimental interventions *(Continued)*

		Assistance from therapist: yes, assisted with swing phase, foot placement, hip and knee extension during stance phase, and weight shift, if required							
Smith 2008	Participants walked for 5 minutes with a "slightly hard" rate of perceived exertion (RPE), then the speed was increased by increments of 0.2 m/hour every 10 minutes of walking with a "slightly hard" RPE	BWS: not clearly stated Hand support: not reported Assistance from therapist: only if required, 2 participants needed slight help with stepping through for the first 2 weeks	20 minutes	12 times per month	4 weeks	Sham (weekly phone calls, recording of a daily life log)	Not reported	1 telephone call per week	4 weeks
Srivastava 2016	2 treadmill groups: group 1 with BWS and group 2 without BWS at gradually increased walking speed	BWS: group 1 yes (40%), group 2 no Hand support: yes Assistance from therapist: not described	30 minutes	5 times per week	4 weeks	Overground task-oriented training	30 minutes	5 times per week	4 weeks
Sullivan 2007	Initially 4 x 5-minute training bouts at individualised speeds, initially within the range of 0.7 to 1.1 m/s, followed by 15 m overground walking and either (1) sham or (2) progressive resistive leg cycling, or (3) individualised progressive resistive strength training	BWS: yes, initially between 30% and 40% of the participant's weight and being decreased as participants improved Hand support: not described Assistance from therapist: up to 3 therapists assisting in placing of both feet	60 minutes	4 times per week	6 weeks	Sham (upper extremity cycle ergometry with minimal physical exertion)	60 minutes	4 times per week	6 weeks

Table 2. Dose of experimental interventions *(Continued)*

		and the pelvis, if necessary							
Suputtitada 2004	Speed was initiated from 0.044 m/s for 10 minutes, followed by a rest for 5 minutes and then increased by increments of 0.044 m/s for 10 minutes	BWS: yes, 30% during the first week, 20% during the second week, I0% during the third week, and no BWS during the fourth week Hand support: unclear Assistance from therapist: initially 2 therapists assisted in placing the foot and the pelvis	25 minutes	7 times per week	4 weeks	Walking at a self-adopted speed on a 15 m walkway for 10 minutes, rested 5 minutes, and walked again 10 minutes	25 minutes	7 times per week	4 weeks
Takami 2010	For 3 minutes twice (with 4 minute rest); week 1: 0.8 km/hour, week 2: 1.0 km/hour, week 3: 1.3 km/hour	BWS: yes 30% Hand support: yes, use of hand rails, if required Assistance from therapist: not described	30 minutes control intervention followed by 10 minutes treadmill training either in forward or backward direction	3 times per week	4 weeks	Conventional training (stretching, strengthening), including overground walking < 200 m and ADL training	80 minutes	5.5 times per week	4 weeks
Toledano-Zarhi 2011	Intervention consisted of treadmill training, training on a hand bike machine, and a stationary bicycle	BWS: not stated Hand support: not stated Assistance from therapist: not stated	90 minutes exercise training, including 35 to 55 minutes treadmill training	2 times per week	6 weeks	Home exercise booklet with included instructions for flexibility and muscle strength exercises, participants were encouraged to stick to their normal community routine	NA	NA	6 weeks

Table 2. Dose of experimental interventions *(Continued)*

Visintin 1998	Gradually increased in increments of 0.04 m/s, from 0.23 to 0.42 m/s, on average, on an individual basis	BWS: yes, starting at 40% body weight and progressively decreased to 0% Hand support: yes, use of hand rails, if required Assistance from therapist: yes, assisted with stepping and limb control during stance and swing phases, and weight shift, if required	20 minutes	4 times per week	6 weeks	Task-orientated (treadmill only) - gradually increased speed from 0.19 to 0.34 m/s, on average, on an individual basis	20 minutes	4 times per week	6 weeks
Weng 2004	Initial speed was half of the measured maximal walking speed prior to training session for 5 minutes as a warm-up, then intervals of higher speed for 10 s were delivered, returning back to warm-up speed for 2 minutes; in the next phase the speed would be increased or decreased by 10%, respectively	BWS: no Hand support: unclear Assistance from therapist: yes, assisted with foot placing and pelvis rotation	20 minutes	5 times per week	4 weeks	Neuromuscular facilitation techniques	20 minutes	5 times per week	4 weeks
Weng 2006	Participants walked backwards on a treadmill with increasing speed	BWS: no Hand support: unclear Assistance from therapist: yes; assisted with foot placing and pelvis rotation	30 minutes of control intervention and 30 minutes of treadmill training	5 times per week	3 weeks	Neuromuscular facilitation techniques including lower limb movements and overground gait exercises	60 minutes	5 times per week	3 weeks
Werner 2002a	Increased from a mean of 0.32 (SD 0.05) m/s at baseline on an individual basis	BWS: yes, starting at a mean of 8.93% (SD 1.84) body weight and progressively decreased	15 to 20 minutes	5 times per week	2 weeks	Task-orientated	15 to 20 minutes	5 times per week	2 weeks

Table 2. Dose of experimental interventions *(Continued)*

		Hand support: yes, use of handrails, if required Assistance from therapist: yes, assisted with foot placement, swing phase, and hip and trunk extension during stance phase, if required							
Yang 2010	Additional to the CTL intervention: Initial BWS of 40% was decreased to the maximum extent, if knee flexion of the paretic limb did not exceed 15°; speed was selected according to the participant's ability	BWS: yes Hand support: no, participants were encouraged to refrain from handrails Assistance from therapist: yes, 1 or 2 therapists assisted	30 minutes + 20 minutes control intervention	3 times per week	4 weeks	Stretching, muscle strengthening, balance, and overground walking training	50 minutes	3 times per week	4 weeks
Yen 2008	Additional to the CTL intervention: Initial BWS of 40% was decreased to the maximum extent, if knee flexion of the paretic limb did not exceed 15°; speed was selected according to the participant's ability	BWS: yes Hand support: no, participants were encouraged to refrain from handrails Assistance from therapist: yes, 1 or 2 therapists assisted	30 minutes + 20 minutes of control intervention	3 times per week	4 weeks	Stretching, muscle strengthening, balance and overground walking training	50 minutes	2 to 3 times per week	4 weeks
Zhang 2008	Increased from 0.2 km/hour and 40% weight-bearing relief according to the participant's capabilities	BWS: yes Hand support: unclear Assistance from therapist: yes, assisted with foot placing, knee extension and pelvis rotation	30 minutes	5 times per week	8 weeks	Not described	Not stated	Not stated	8 weeks
Zhu 2004	Walking speed and BWS were individualised to the	BWS: yes	Individualised	5 times a week	4 weeks	Individualised conventional mo-	Not stated	5 times a week	4 weeks

Table 2. Dose of experimental interventions *(Continued)*

	participants' capabilities (with a mean walking speed of 0.13 m/s at baseline and 0.17 m/s at the end of the intervention phase)	Hand support: unclear Assistance from therapist: unclear	tor rehabilitation aiming at improving strength and endurance

ADL: activities of daily living
BWS: body weight support
BWSTT: body weight support treadmill training
CTL: control
EXP: experimental
GT: gait trainer
HRR: heart rate reserve
NA: not applicable
PNF: Proprioceptive Neuromuscular Facilitation
RPE: rate of perceived exertion
SE: standard error
SD: standard deviation
TTBWS: treadmill training with body weight support
VO2: volume of oxygen consumption

Table 3. Adverse events during the treatment

Study ID	Injurious falls	Other injuries	Cardiovascular event	Other adverse event
Ada 2003	EXP = 1 (hip fracture caused by a fall at home after the first week of training) CTL = 0	EXP = 1 (missed post-treatment measurement session due to low back pain) CTL = 0	EXP = 0 CTL = 0	EXP = 1 (fall during overground component of training but no injuries sustained) CTL = 0
Ada 2010	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 47 reports CTL = 27 reports All reports included musculoskeletal problems (back, hip, knee, calf, foot pain, and gout), headaches, dizziness, or chest pain. There were 6 reports of falling, 1 of which resulted in a fracture and none of which occurred during the delivery of the intervention. 2 participants in the experimental group experienced anxiety attributable to being on a treadmill that was severe enough for them to withdraw from the study.
Ada 2013	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Bonnyaud 2013	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Bonnyaud 2013a	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Combs-Miller 2014	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Da Cunha Filho 2002	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Deniz 2011	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
DePaul 2015	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Du 2006	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Duncan 2011	EXP = 0 CTL = 0	EXP = 16 (fracture) CTL = not reported	EXP = 1 (myocardial infarction) CTL = 1 (myocardial infarction)	EXP = 139 + 143 (all reported events) CTL = 126 (all reported events)
Eich 2004	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0

Table 3. Adverse events during the treatment *(Continued)*

Franceschini 2009	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Gama 2017	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Gan 2012	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Globas 2011	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 1 recurrent stroke, 1 transportation problem CTL = 0
Hoyer 2012	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Jaffe 2004	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Kang 2012	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Kim 2011	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Kim 2016	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Kosak 2000	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 1 (acute myocardial infarction 2 days after last treatment session) CTL = 1 (stroke progression)	EXP = 0 CTL = 0
Kuys 2011	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Langhammer 2010	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Laufer 2001	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Liston 2000	EXP = 0 CTL = not reported	EXP = 1 (knee pain after first 4 treadmill sessions) CTL = not reported	EXP = 0 CTL = not reported	EXP = 1 (hospitalised after first training session and subsequently died, reason for hospitalisation not reported) CTL = not reported
Luft 2008	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
MacKay-Lyons 2013	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0

Table 3. Adverse events during the treatment *(Continued)*

Macko 2005	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 11 (5 falls during treadmill training but no injuries sustained; 6 minor medical complications) CTL = 0
Mao 2015	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Mehrberg 2001	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Middleton 2014	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Moore 2010	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Nilsson 2001	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Olawale 2009	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Park 2013	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Park 2015	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Pohl 2002	EXP 1 = 0 EXP 2 = 0 CTL = 0	EXP 1 = 0 EXP 2 = 0 CTL = 0	EXP 1 = 0 EXP 2 = 0 CTL = 0	EXP 1 = 0 EXP 2 = 1 (vertigo, but did not have to terminate training) CTL = 0
Ribeiro 2013	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Richards 1993	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Richards 2004	EXP = not reported CTL = not reported	EXP = 1 (hip fracture) CTL = not reported	EXP = 1 (cardiac problems) CTL = not reported	EXP = not reported CTL = not reported
Scheidtmann 1999	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Smith 2008	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Srivastava 2016	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Sullivan 2007	EXP = 7 CTL = 2			
Suputtitada 2004	EXP = not reported	EXP = not reported	EXP = not reported	EXP = not reported

Table 3. Adverse events during the treatment *(Continued)*

	CTL = not reported	CTL = not reported	CTL = not reported	CTL = not reported
Takami 2010	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Toledano-Zarhi 2011	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Visintin 1998	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Weng 2004	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Weng 2006	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Werner 2002a	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0	EXP = 0 CTL = 0
Yang 2010	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Yen 2008	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Zhang 2008	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported
Zhu 2004	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported	EXP = not reported CTL = not reported

CTL: control
EXP: experimental

Table 4. Dropouts

Study ID	EXP - treatment phase	EXP - follow-up	CTL - treatment	CTL - follow-up
Ada 2003	1 - hip fracture caused by a fall at home after the first week of training 2 - not measured at post-test for medical reasons, 1 due to low back pain (these participants completed the follow-up assessment)	No dropouts	1 - moved out of area	1 - moved out of area
Ada 2010	2 - died 2 - withdrew	No follow-up period	2 - died	No follow-up period
Ada 2013	1 - withdrew	No dropouts	3 - withdrew	No dropouts
Bonnyaud 2013	No dropouts	No dropouts	No dropouts	No dropouts
Bonnyaud 2013a	No dropouts	No dropouts	No dropouts	No dropouts

Table 4. Dropouts *(Continued)*

Combs-Miller 2014	2 dropouts	No dropouts	No dropouts	No dropouts
Da Cunha Filho 2002	1 - completed fewer than 9 treadmill and body weight support sessions	No follow-up period	1 - pulmonary complications (not related to the protocol)	No follow-up period
Deniz 2011	Dropouts not stated	Dropouts not stated	Dropouts not stated	Dropouts not stated
DePaul 2015	1 dropout	3 dropouts	5 dropouts	4 dropouts
Du 2006	No dropouts	No follow-up period	No dropouts	No follow-up period
Duncan 2011	35 (12 withdrew, 7 died, 13 moved, 3 other)	Unclear	11 (2 withdrew, 6 died, 3 moved)	
Eich 2004	No dropouts	1 - refusal	No dropouts	No dropouts
Franceschini 2009	10 - dropouts	No follow-up period	10 - dropouts	No follow-up period
Gama 2017	2 - dropouts	No dropouts	2 - dropouts	No dropouts
Gan 2012	No dropouts	No follow-up period	No dropouts	No follow-up period
Globas 2011	1 - recurrent stroke 1 - transportation problem	2 dropouts (but unclear which group)	No dropouts	2 dropouts (but unclear which group)
Hoyer 2012	No dropouts	No follow-up period	No dropouts	No follow-up period
Jaffe 2004	1 - endurance level too low to continue treatment	No dropouts	2 - medical conditions unrelated to the study (1 participant with arthritis and 1 participant with a heart condition)	No dropouts
Kang 2012	1 - dropout - another treatment 1 - lack of participation	No dropouts	No dropouts	No dropouts
Kim 2011	Dropouts not stated	Dropouts not stated	Dropouts not stated	Dropouts not stated
Kim 2016	No dropouts	No follow-up period	3 dropouts in the control group without additional training	No follow-up period
Kosak 2000	1 - chose to discontinue treatment (did not want to walk on the treadmill) 1 - acute myocardial infarction requiring readmission to acute care	No follow-up period	1 - Stroke progression requiring readmission to acute care	No follow-up period
Kuys 2011	1 - withdrew	1 - moved	No dropouts	No dropouts

Table 4. Dropouts *(Continued)*

	1 - fall	1 - medical condition		
Langhammer 2010	3 - dropouts (unclear reasons)	No follow-up period	2 - dropouts (unclear reasons)	No follow-up period
Laufer 2001	2 - discharged prior to completion of data collection	No follow-up period	1 - discharged prior to completion of data collection 1 - readmitted to an acute hospital (not related to the protocol)	No follow-up period
Liston 2000	1 - hospitalised after first treatment and subsequently died (reason for hospitalisation not reported) 1 - chose to discontinue treatment due to knee pain 1 - chose to discontinue treatment (felt unsafe and frightened on the treadmill)	No follow-up period	No dropouts	No follow-up period
Luft 2008	12 - unrelated medical condition 2 - recurrent stroke 6 - noncompliance	No follow-up period	11 - unrelated medical condition 11 - noncompliance	No follow-up period
MacKay-Lyons 2013	1 - seizure activity 1 - moved	1 - refused	2 - medical reasons 1 - disinterest	1 - refused 1 - lost to follow-up
Macko 2005	3 - medical conditions (1 participant had sinus surgery, 1 participant had pre-existing shoulder pain, 1 participant had a gastrointestinal bleed and recurrent stroke) 1 - fall at home 3 - chose to discontinue treatment (1 participant had transportation problems, 1 participant had poor adherence, and 1 participant decided to train at home)	No follow-up period	4 - medical conditions (1 participant had a hernia repair, 1 participant had elective cardiac surgery, 1 participant had a radiculopathy, and 1 participant had a foot infection and poor control of hypertension) 2 - fracture caused by a fall at home 3 - chose to discontinue treatment (1 participant moved out of area, 1 participant returned to work, and 1 participant was disinterested in stretching)	No follow-up period
Mao 2015	1 - discontinued treatment, cardiovascular instability 2 - discontinued treatment, early discharged	No follow-up period	2- discontinued treatment, early discharge	No follow-up period
Mehrberg 2001	Missing information	Missing information	Missing information	Missing information

Table 4. Dropouts *(Continued)*

Middleton 2014	4 - discontinued treatment, lost to follow-up, unable to contact	No follow-up period	1- discontinued treatment, lost to follow-up, unable to contact	
Moore 2010	Authors stated: 10 did not complete the protocol because of noncompliance with study requirements (i.e. not wearing accelerometer, n = 5), early discharge from clinical PT (n = 2), orthopaedic injury which limited walking (n = 1), or previous diagnosis of secondary neurological injuries (n = 2).			
Nilsson 2001	2 - chose to discontinue treatment (did not want to walk on the treadmill) 2 - medical reasons	2 - medical reasons 1 - death 1 - moved out of area	1 - chose to discontinue treatment (wanted to walk on the treadmill) 1 - medical reasons 1 - death	1 - moved out of area 1 - did not want to attend the follow-up tests
Olawale 2009	2 - did not attend all training sessions	No follow-up period	5 - Did not attend all training sessions	No follow-up period
Park 2013	none	No follow-up period	None	No follow-up period
Park 2015	none	No follow-up period	None	No follow-up period
Pohl 2002	2 - medical conditions (1 participant with bladder infection and fever, and 1 participant with viral infection and fever) from EXP 1 2 - medical conditions (1 participant with bladder infection and fever, and 1 participant with pneumonia) from EXP 2	No follow-up period	5 - medical conditions (3 participants with pneumonia and 2 with viral infection and fever)	No follow-up period
Ribeiro 2013	2 - dropouts	No follow-up period	3 - dropouts	No follow-up period
Richards 1993	1 - reason not reported	No follow-up data reported	2 - reason not reported	No follow-up data reported
Richards 2004	1 - medical conditions (hip fracture) 1 - medical conditions (cardiac problems)	5 - being unavailable	1 - reason not stated	7 - being unavailable
Scheidtmann 1999	No dropouts	No follow-up period	No dropouts	No follow-up period
Smith 2008	Dropouts not stated	Dropouts not stated	Dropouts not stated	Dropouts not stated
Srivastava 2016	4 - dropouts	No follow-up period	4 - dropouts	No follow-up period
Sullivan 2007	6 - withdrawn by administration 1 - refused to participate	4 - refused to participate	2 - withdrawn by administration	1 - withdrawn by administration 3 - refused to participate

Table 4. Dropouts *(Continued)*

Suputtitada 2004	Dropouts not stated	No follow-up period	Dropouts not stated	No follow-up period
Takami 2010	3 - for family reasons	No follow-up period	Dropouts not stated	No follow-up period
Toledano-Zarhi 2011	1 - chose to discontinue treatment	No follow-up period	No dropouts	No follow-up period
Visintin 1998	2 - chose to discontinue treatment 2 - medical reasons 2 - discharged to chronic care prior to completion of data collection (no longer eligible) 1 - discharged home prior to completion of data collection and was unwilling or unable to complete the training	14 - medical event, repeated stroke, lack of willingness to participate or moved away from area	4 - chose to discontinue treatment 5 - medical reasons 3 - discharged to chronic care prior to completion of data collection (no longer eligible) 2 - discharged home prior to completion of data collection and were unwilling or unable to complete the training	13 - medical event, repeated stroke, lack of willingness to participate or moved away from area
Weng 2004	2 - reasons unknown due to issues of translation	No follow-up period	3 - reasons unknown due to issues of translation	No follow-up period
Weng 2006	Dropouts not stated	No follow-up period	Dropouts not stated	No follow-up period
Werner 2002a	No dropouts	No follow-up period	No dropouts	No follow-up period
Yang 2010	No dropouts	No follow-up period	No dropouts	No follow-up period
Yen 2008	No dropouts	No follow-up period	No dropouts	No follow-up period
Zhang 2008	Dropouts not stated	No follow-up period	Dropouts not stated	No follow-up period
Zhu 2004	No dropouts	No follow-up period	No dropouts	No follow-up period

CTL: control
EXP: experimental
PT: physiotherapy

APPENDICES

Appendix 1. Cochrane Central Register of Controlled Trials (CENTRAL)

#1. [mh ^"cerebrovascular disorders"] or [mh "basal ganglia cerebrovascular disease"] or [mh "brain ischemia"] or [mh "carotid artery diseases"] or [mh "intracranial arterial diseases"] or [mh "intracranial embolism and thrombosis"] or [mh "intracranial hemorrhages"] or [mh ^stroke] or [mh "brain infarction"] or [mh ^"stroke, lacunar"] or [mh ^"vasospasm, intracranial"] or [mh ^"vertebral artery dissection"]
#2. stroke or poststroke or "post-stroke" or cerebrovasc* or brain next vasc* or cerebral next vasc* or cva* or apoplex* or SAH
#3. (brain* or cerebr* or cerebell* or intracran* or intracerebral) near/5 (isch*emi* or infarct* or thrombo* or emboli* or occlus*)
#4. (brain* or cerebr* or cerebell* or intracerebral or intracranial or subarachnoid) near/5 (haemorrhage* or hemorrhage* or haematoma* or hematoma* or bleed*)

#5. [mh ^hemiplegia] or [mh paresis]
#6. hemipleg* or hemipar* or paresis or paretic
#7. [mh ^"gait disorders, neurologic"]
#8. #1 or #2 or #3 or #4 or #5 or #6 or #7
#9. [mh ^exercise] or [mh ^"exercise test"] or [mh ^"exercise therapy"] or [mh ^"motion therapy, continuous passive"]
#10. [mh ^"body weight"] or [mh ^weight-bearing]
#11. treadmill* or tread next mill* or running next wheel* or running next machine*
#12. (walking or walk or exercise) near/5 (machine* or device*)
#13. (walking or gait or locomotor or ambulation) near/5 (train* or re-train* or retrain*)
#14. [mh ^walking]
#15. machine* or device* or train* or re-train* or retrain*
#16. #14 and #15
#17. (weight or "body-weight" or bodyweight) near/5 (support* or suspen* or relief)
#18. (walk or walking or ambulat* or locomot* or gait or overhead) near/5 support*
#19. harness*
#20. #9 or #10 or #11 or #12 or #13 or #16 or #17 or #18 or #19
#21. [mh ^walking] or [mh ^gait] or [mh ^"mobility limitation"] or [mh ^locomotion]
#22. walk* or gait* or ambulat* or mobil* or locomot* or stride
#23. #21 or #22
#24. #8 and #20 and #23

Appendix 2. MEDLINE ovid search strategy

1. cerebrovascular disorders/ or exp basal ganglia cerebrovascular disease/ or exp brain ischemia/ or exp carotid artery diseases/ or exp intracranial arterial diseases/ or exp "intracranial embolism and thrombosis"/ or exp intracranial hemorrhages/ or stroke/ or exp brain infarction/ or stroke, lacunar/ or vasospasm, intracranial/ or vertebral artery dissection/
2. (stroke or poststroke or post-stroke or cerebrovasc$ or brain vasc$ or cerebral vasc$ or cva$ or apoplex$ or SAH).tw.
3. ((brain$ or cerebr$ or cerebell$ or intracran$ or intracerebral) adj5 (isch?emi$ or infarct$ or thrombo$ or emboli$ or occlus$)).tw.
4. ((brain$ or cerebr$ or cerebell$ or intracerebral or intracranial or subarachnoid) adj5 (haemorrhage$ or hemorrhage$ or haematoma $ or hematoma$ or bleed$)).tw.
5. hemiplegia/ or exp paresis/
6. (hemipleg$ or hemipar$ or paresis or paretic).tw.
7. exp gait disorders, neurologic/
8. 1 or 2 or 3 or 4 or 5 or 6 or 7
9. exercise/ or exercise test/ or exercise therapy/ or motion therapy, continuous passive/
10. body weight/ or weight-bearing/
11. (treadmill$ or tread mill$ or running wheel$ or running machine$).tw.
12. ((walking or walk or exercise) adj5 (machine$ or device$)).tw.
13. ((walking or gait or locomotor or ambulation) adj5 (train$ or re-train$ or retrain$)).tw.
14. exp walking/ and (machine$ or device$ or train$ or re-train$ or retrain$).tw.
15. ((weight or body-weight or bodyweight) adj5 (support$ or suspen$ or relief)).tw.
16. ((walk or walking or ambulat$ or locomot$ or gait or overhead) adj5 support$).tw.
17. harness$.tw.
18. 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17
19. exp walking/ or gait/ or mobility limitation/ or locomotion/
20. (walk$ or gait$ or ambulat$ or mobil$ or locomot$ or stride).tw.
21. 19 or 20
22. Randomized Controlled Trials as Topic/
23. random allocation/
24. Controlled Clinical Trials as Topic/
25. control groups/
26. clinical trials as topic/
27. double-blind method/
28. single-blind method/
29. Placebos/
30. placebo effect/
31. cross-over studies/
32. Therapies, Investigational/
33. Research Design/
34. randomized controlled trial.pt.
35. controlled clinical trial.pt.
36. clinical trial.pt.

37. (random$ or RCT or RCTs).tw.
38. (controlled adj5 (trial$ or stud$)).tw.
39. (clinical$ adj5 trial$).tw.
40. ((control or treatment or experiment$ or intervention) adj5 (group$ or subject$ or patient$)).tw.
41. (quasi-random$ or quasi random$ or pseudo-random$ or pseudo random$).tw.
42. ((control or experiment$ or conservative) adj5 (treatment or therapy or procedure or manage$)).tw.
43. ((singl$ or doubl$ or tripl$ or trebl$) adj5 (blind$ or mask$)).tw.
44. (cross-over or cross over or crossover).tw.
45. (placebo$ or sham).tw.
46. trial.ti.
47. (assign$ or allocat).tw.
48. or/22-47
49. 8 and 18 and 21 and 48
50. exp animals/ not humans.sh.
51. 49 not 50

Appendix 3. Embase ovid search strategy

1. cerebrovascular disease/ or exp basal ganglion hemorrhage/ or exp brain hematoma/ or exp brain hemorrhage/ or exp brain infarction/ or exp brain ischemia/ or exp carotid artery disease/ or cerebral artery disease/ or exp cerebrovascular accident/ or exp intracranial aneurysm/ or exp occlusive cerebrovascular disease/ or vertebrobasilar insufficiency/
2. stroke patient/ or stroke unit/
3. exp neurologic gait disorder/ or hemiparesis/ or hemiplegia/ or paresis/
4. (stroke or poststroke or post-stroke or cerebrovasc$ or brain vasc$ or cerebral vasc$ or cva$ or apoplex$ or SAH).tw.
5. ((brain$ or cerebr$ or cerebell$ or intracran$ or intracerebral) adj5 (isch?emi$ or infarct$ or thrombo$ or emboli$ or occlus$)).tw.
6. ((brain$ or cerebr$ or cerebell$ or intracerebral or intracranial or subarachnoid) adj5 (haemorrhage$ or hemorrhage$ or haematoma $ or hematoma$ or bleed$)).tw.
7. (hemipleg$ or hemipar$ or paresis or paretic).tw.
8. 1 or 2 or 3 or 4 or 5 or 6 or 7
9. treadmill/ or treadmill exercise/ or treadmill ergometry/
10. walking harness/ or walking machine/
11. exp exercise/ or exp kinesiotherapy/ or exercise test/
12. body weight/ or weight bearing/
13. (treadmill$ or tread mill$ or running wheel$ or running machine$).tw.
14. ((walking or walk or exercise) adj5 (machine$ or device$)).tw.
15. ((walking or gait or locomotor or ambulation) adj5 (train$ or re-train$ or retrain$)).tw.
16. exp walking/ and (machine$ or device$ or train$ or re-train$ or retrain$).tw.
17. ((weight or body-weight or bodyweight) adj5 (support$ or suspen$ or relief)).tw.
18. ((walk or walking or ambulat$ or locomot$ or gait or overhead) adj5 support$).tw.
19. harness$.tw.
20. 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
21. walking/ or walking speed/ or gait/ or locomotion/ or walking difficulty/
22. (walk$ or gait$ or ambulat$ or mobil$ or locomot$ or stride).tw.
23. 21 or 22
24. Randomized Controlled Trial/
25. Randomization/
26. Controlled Study/
27. control group/
28. clinical trial/
29. Crossover Procedure/
30. Double Blind Procedure/
31. Single Blind Procedure/ or triple blind procedure/
32. placebo/
33. "types of study"/
34. random$.tw.
35. (controlled adj5 (trial$ or stud$)).tw.
36. (clinical$ adj5 trial$).tw.
37. ((control or treatment or experiment$ or intervention) adj5 (group$ or subject$ or patient$)).tw.
38. (quasi-random$ or quasi random$ or pseudo-random$ or pseudo random$).tw.
39. ((control or experiment$ or conservative) adj5 (treatment or therapy or procedure or manage$)).tw.
40. ((singl$ or doubl$ or tripl$ or trebl$) adj5 (blind$ or mask$)).tw.
41. (cross-over or cross over or crossover).tw.

42. placebo$.tw.
43. sham.tw.
44. (assign$ or allocat$).tw.
45. trial.ti. or (RCT or RCT).tw.
46. or/24-45
47. 8 and 20 and 23 and 46
48. exp animals/ or exp invertebrate/ or animal experiment/ or animal model/ or animal tissue/ or animal cell/ or nonhuman/
49. human/ or normal human/ or human cell/
50. 48 not 49
51. 47 not 50

Appendix 4. CINAHL EBSCO search strategy

S48. S13 AND S24 AND S28 AND S47
S47. S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S40 OR S41 OR S44 OR S45 OR S46
S46. TI trial OR (TI (RCT or RCTs) OR AB (RCT or RCTs))
S45. TI (counterbalance* or multiple baseline* or ABAB design) or AB (counterbalance* or multiple baseline* or ABAB design)
S44. S42 and S43
S43. TI trial* or AB trial*
S42. TI (clin* or intervention* or compar* or experiment* or preventive or therapeutic) or AB (clin* or intervention* or compar* or experiment* or preventive or therapeutic)
S41. TI (crossover or cross-over or placebo* or control* or factorial or sham) or AB (crossover or cross-over or placebo* or control* or factorial or sham)
S40. S38 and S39
S39. TI (blind* or mask*) or AB (blind* or mask*)
S38. TI (singl* or doubl* or tripl* or trebl*) or AB (singl* or doubl* or tripl* or trebl*)
S37. TI random* or AB random*
S36. (MH "Community Trials") or (MH "Experimental Studies") or (MH "One-Shot Case Study") or (MH "Pretest-Posttest Design+") or (MH "Solomon Four-Group Design") or (MH "Static Group Comparison") or (MH "Study Design")
S35. (MH "Clinical Research") or (MH "Clinical Nursing Research")
S34. (MH "Placebo Effect") or (MH "Placebos") or (MH "Meta Analysis")
S33. (MH "Factorial Design") or (MH "Quasi-Experimental Studies") or (MH "Nonrandomized Trials")
S32. (MH "Control (Research)") or (MH "Control Group")
S31. (MH "Crossover Design") or (MH "Clinical Trials+") or (MH "Comparative Studies")
S30. (MH "Random Assignment") or (MH "Random Sample+")
S29. PT randomized controlled trial or clinical trial
S28. S25 OR S26 OR S27
S27. TI (walk* or gait* or ambulat* or mobil* or locomot* or stride) OR AB (walk* or gait* or ambulat* or mobil* or locomot* or stride)
S26. (MH "Gait Analysis") OR (MH "Gait Training")
S25. (MH "Locomotion") OR (MH "Walking") OR (MH "Gait") OR (MH "Step")
S24. S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23
S23. TI harness* OR AB harness*
S22. (TI (walk or walking or ambulat* or locomot* or gait or overhead) OR AB (walk or walking or ambulat* or locomot* or gait or overhead)) AND (TI support* OR AB support*)
S21. (TI (weight or body-weight or bodyweight) OR AB (weight or body-weight or bodyweight)) AND (TI (support* or suspen* or relief) OR AB (support* or suspen* or relief))
S20. ((MH "Walking") OR (MH "Gait training")) AND (TI (machine* or device* or train* or re-train* or retrain*) OR AB (machine* or device* or train* or re-train* or retrain*))
S19. (TI (walking or gait or locomotor or ambulation) OR AB (walking or gait or locomotor or ambulation)) AND (TI (train* or re-train* or retrain*) OR AB (train* or re-train* or retrain*))
S18. (TI (walking or walk or exercise) OR AB (walking or walk or exercise)) AND (TI (machine* or device*) OR AB (machine* or device*))
S17. TI (treadmill* or tread mill* or running wheel* or running machine*) OR AB (treadmill* or tread mill* or running wheel* or running machine*)
S16. (MH "Weight-Bearing") or (MH "Body Weight")
S15. (MH "Exercise+") or (MH "Therapeutic Exercise+") or (MH "Exercise Test")
S14. (MH "Treadmills")
S13. S1 OR S2 OR S3 OR S6 OR S9 OR S10 OR S11 OR S12
S12. (MH "Gait Disorders, Neurologic+")
S11. TI (hemipleg* or hemipar* or paresis or paretic) or AB (hemipleg* or hemipar* or paresis or paretic)
S10. (MH "Hemiplegia")
S9. S7 and S8

S8. TI (haemorrhage* or hemorrhage* or haematoma* or hematoma* or bleed*) or AB (haemorrhage* or hemorrhage* or haematoma* or hematoma* or bleed*)
S7. TI (brain* or cerebr* or cerebell* or intracerebral or intracranial or subarachnoid) or AB (brain* or cerebr* or cerebell* or intracerebral or intracranial or subarachnoid)
S6. S4 and S5
S5. TI (ischemi* or ischaemi* or infarct* or thrombo* or emboli* or occlus*) or AB (ischemi* or ischaemi* or infarct* or thrombo* or emboli* or occlus*)
S4. TI (brain* or cerebr* or cerebell* or intracran* or intracerebral) or AB (brain* or cerebr* or cerebell* or intracran* or intracerebral)
S3. TI (stroke or poststroke or post-stroke or cerebrovasc* or brain vasc* or cerebral vasc or cva or apoplex or SAH) or AB (stroke or poststroke or post-stroke or cerebrovasc* or brain vasc* or cerebral vasc or cva or apoplex or SAH)
S2. (MH "Stroke Patients") OR (MH "Stroke Units")
S1. (MH "Cerebrovascular Disorders") OR (MH "Basal Ganglia Cerebrovascular Disease+") OR (MH "Carotid Artery Diseases+") OR (MH "Cerebral Ischemia+") OR (MH "Cerebral Vasospasm") OR (MH "Intracranial Arterial Diseases+") OR (MH "Intracranial Embolism and Thrombosis") OR (MH "Intracranial Hemorrhage+") OR (MH "Stroke") OR (MH "Vertebral Artery Dissections")

Appendix 5. AMED Ovid (Allied and Complementary Medicine) search strategy

1. cerebrovascular disorders/ or cerebral hemorrhage/ or cerebral infarction/ or cerebral ischemia/ or cerebrovascular accident/ or stroke/
2. (stroke or poststroke or post-stroke or cerebrovasc$ or brain vasc$ or cerebral vasc$ or cva$ or apoplex$ or SAH).tw.
3. ((brain$ or cerebr$ or cerebell$ or intracran$ or intracerebral) adj5 (isch?emi$ or infarct$ or thrombo$ or emboli$ or occlus$)).tw.
4. ((brain$ or cerebr$ or cerebell$ or intracerebral or intracranial or subarachnoid) adj5 (haemorrhage$ or hemorrhage$ or haematoma $ or hematoma$ or bleed$)).tw.
5. hemiplegia/ or gait disorders/
6. (hemipleg$ or hemipar$ or paresis or paretic).tw.
7. 1 or 2 or 3 or 4 or 5 or 6
8. exercise/ or exercise testing/ or exercise therapy/ or continuous passive motion/
9. body weight/ or weight bearing/
10. (treadmill$ or tread mill$ or running wheel$ or running machine$).tw.
11. ((walking or walk or exercise) adj5 (machine$ or device$)).tw.
12. ((walking or gait or locomotor or ambulation) adj5 (train$ or re-train$ or retrain$)).tw.
13. exp walking/ and (machine$ or device$ or train$ or re-train$ or retrain$).tw.
14. ((weight or body-weight or bodyweight) adj5 (support$ or suspen$ or relief)).tw.
15. ((walk or walking or ambulat$ or locomot$ or gait or overhead) adj5 support$).tw.
16. harness$.tw.
17. 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16
18. exp walking/ or gait/ or locomotion/ or mobility limitation/ or gait analysis/
19. (walk$ or gait$ or ambulat$ or mobil$ or locomot$ or stride).tw.
20. 18 or 19
21. 7 and 17 and 20
22. (clinical trial or clinical trial phase iii or clinical trialb or clinical trials or controlled clinical trial or controlled trial or randomised controlled trial or randomized controlled trial).pt.
23. clinical trials/ or randomized controlled trials/ or double blind method/ or random allocation/
24. (random$ or RCT or RCTs).tw.
25. (controlled adj5 (trial$ or stud$)).tw.
26. (clinical$ adj5 trial$).tw.
27. ((control or treatment or experiment$ or intervention) adj5 (group$ or subject$ or patient$)).tw.
28. (quasi-random$ or quasi random$ or pseudo-random$ or pseudo random$).tw.
29. ((control or experiment$ or conservative) adj5 (treatment or therapy or procedure or manage$)).tw.
30. ((singl$ or doubl$ or tripl$ or trebl$) adj5 (blind$ or mask$)).tw.
31. (cross-over or cross over or crossover).tw.
32. (placebo$ or sham).tw.
33. trial.ti.
34. (assign$ or allocat).tw.
35. or/22-34
36. 21 and 35

Appendix 6. SPORTDiscus EBSCO search strategy

S30. S28 AND S29
S29. TI (random* or RCT or trial* or placebo* or sham or double-blind* or single-blind or control or controls or assign* or allocat*) OR AB (random* or RCT or trial* or placebo* or sham or double-blind* or single-blind or control or controls or assign* or allocat*)
S28. S13 AND S24 AND S27
S27. S25 OR S26

S26. TI (walk* or gait* or ambulat* or mobil* or locomot* or stride) OR AB (walk* or gait* or ambulat* or mobil* or locomot* or stride)
S25. (DE "WALKING" OR DE "GAIT in humans") AND (DE "LOCOMOTION" OR DE "HUMAN locomotion")
S24. S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23
S23. TI harness* OR AB harness*
S22. (TI (walk or walking or ambulat* or locomot* or gait or overhead) OR AB (walk or walking or ambulat* or locomot* or gait or overhead)) AND (TI support* OR AB support*)
S21. (TI (weight or body-weight or bodyweight) OR AB (weight or body-weight or bodyweight)) AND (TI (support* or suspen* or relief) OR AB (support* or suspen* or relief))
S20. (DE "WALKING" OR DE "FITNESS walking" OR DE "GAIT in humans") AND (TI (machine* or device* or train* or re-train* or retrain*) OR AB (machine* or device* or train* or re-train* or retrain*))
S19. (TI (walking or gait or locomotor or ambulation) OR AB (walking or gait or locomotor or ambulation)) AND (TI (train* or re-train* or retrain*) OR AB (train* or re-train* or retrain*))
S18. (TI (walking or walk or exercise) OR AB (walking or walk or exercise)) AND (TI (machine* or device*) OR AB (machine* or device*))
S17. TI (treadmill* or tread mill* or running wheel* or running machine*) OR AB (treadmill* or tread mill* or running wheel* or running machine*)
S16. (DE "BODY weight") OR (DE "WEIGHT-bearing (Orthopedics)")
S15. DE "EXERCISE" OR DE "AEROBIC exercises" OR DE "EXERCISE for people with disabilities" OR DE "EXERCISE therapy" OR DE "KNEE exercises" OR DE "LEG exercises" OR DE "STRENGTH training" OR DE "EXERCISE therapy" OR DE "EXERCISE tests" OR DE "EXERCISE -- Equipment & supplies"
S14. DE "TREADMILL exercise tests" OR DE "TREADMILL exercise" OR DE "TREADMILLS (Exercise equipment)"
S13. S1 or S2 or S3 or S4 or S7 or S10 or S11 or S12
S12. DE "GAIT disorders"
S11. TI (hemipleg* or hemipar* or paresis or paretic) or AB (hemipleg* or hemipar* or paresis or paretic)
S10. S8 and S9
S9. TI (haemorrhage* or hemorrhage* or haematoma* or hematoma* or bleed*) or AB (haemorrhage* or hemorrhage* or haematoma* or hematoma* or bleed*)
S8. TI (brain* or cerebr* or cerebell* or intracerebral or intracranial or subarachnoid) or AB (brain* or cerebr* or cerebell* or intracerebral or intracranial or subarachnoid)
S7. S5 and S6
S6. TI (ischemi* or ischaemi* or infarct* or thrombo* or emboli* or occlus*) or AB (ischemi* or ischaemi* or infarct* or thrombo* or emboli* or occlus*)
S5. TI (brain* or cerebr* or cerebell* or intracran* or intracerebral) or AB (brain* or cerebr* or cerebell* or intracran* or intracerebral)
S4. TI (stroke or poststroke or post-stroke or cerebrovasc* or brain vasc* or cerebral vasc or cva or apoplex or SAH) or AB (stroke or poststroke or post-stroke or cerebrovasc* or brain vasc* or cerebral vasc or cva or apoplex or SAH)
S3. DE "HEMIPLEGIA" OR DE "HEMIPLEGICS"
S2. DE "CEREBROVASCULAR disease -- Patients"
S1. DE "CEREBROVASCULAR disease" OR DE "BRAIN -- Hemorrhage" OR DE "CEREBRAL embolism & thrombosis"

Appendix 7. US National Institutes of Health Ongoing Trials Register (ClinicalTrials.gov) search strategy

(stroke OR CVA OR CVI OR (cerebrovasc* (accid* OR incid))) AND (walk* OR ambul* OR treadmill) | Interventional Studies | Adult, Senior

Number of hits: 107

Appendix 8. World Health Organization International Clinical Trials Registry Platform search strategy

#1 stroke OR CVA OR CVI

#2 ambul* OR walk* OR treadmill

3 #1 AND #2

Number of hits: 3

WHAT'S NEW

Date	Event	Description
21 March 2017	New citation required and conclusions have changed	The conclusions of the review have changed. The previous version of this review concluded that, overall, no statistically significant effect of treadmill training with or without body weight support could be detected. This updated version concludes that

Date	Event	Description
		overall walking ability was not improved but a statistically significant effect of treadmill training with or without body weight support was detected for improving walking speed and walking endurance. This review did not find, however, that improvements in walking speed and endurance may have persisting beneficial effects. The authorship of the review has changed for the update of this review.
21 March 2017	New search has been performed	We have updated the searches to March 2017 and revised the text as appropriate. We have included 56 trials, with 3105 participants, in this update compared with 44 trials, with 2658 participants, in the last updated version of this review from 2014.

HISTORY

Protocol first published: Issue 4, 2000
Review first published: Issue 3, 2003

Date	Event	Description
30 August 2013	New search has been performed	We have updated the searches to June 2013 and revised the text as appropriate. We have included 44 trials with 2658 participants in this update compared with 15 trials with 622 participants in the last version of this review from 2005.
15 August 2013	New citation required and conclusions have changed	The conclusions of the review have changed. The previous version of this review concluded that, overall, no statistically significant effect of treadmill training with or without body weight support could be detected. This updated version concludes that overall walking ability was not improved but a statistically significant effect of treadmill training with or without body weight support was detected for improving walking speed and walking endurance. The authorship of the review has changed.
18 August 2008	Amended	Converted to new review format.
14 April 2005	New search has been performed	The search for trials was extended from March 2003 to March 2005. Four trials (Eich 2004; Jaffe 2004; Macko 2005; Werner 2002a) and one outcome measure (walking endurance) have been added to our original review. We have been able to obtain individual patient data for another trial (Visintin 1998).

CONTRIBUTIONS OF AUTHORS

On 28 March 2013, we were contacted by the Cochrane Stroke Group and our author team took over this review and updated it from 2005. We contacted the former review team from 2005 and received all requested data. We used the data collection provided by the former review team and, based on this information, we updated the review by including all eligible studies published from 2005 onwards.

For this 2017 update, BE and JM conducted the literature selection, data extraction, and analyses, and were responsible for the major content of the review. BE, JM, and ST interpreted the data from the individual trials and the statistically-pooled results, and contributed to the manuscript. All authors edited the manuscript.

DECLARATIONS OF INTEREST

Bernhard Elsner: none known.
Simone Thomas: none known.
Jan Mehrholz: author of one included trial (Pohl 2002). He did not participate in quality assessment and data extraction for this study.

SOURCES OF SUPPORT

Internal sources

- Rehabilitation Studies Unit, Northern Clinical School, Faculty of Medicine, The University of Sydney, Australia.
- School of Physiotherapy, The University of Sydney, Australia.
- Department of Public Health, Medizinische Fakultät 'Carl Gustav Carus', TU Dresden, Germany.
- Wissenschaftliches Institut, Private Europäische Medizinische Akademie der Klinik Bavaria in Kreischa GmbH, An der Wolfsschlucht 1-201731 Kreischa, Germany.

External sources

- No sources of support supplied

DIFFERENCES BETWEEN PROTOCOL AND REVIEW

In the protocol, it was stated that we would use the PEDro Scale to assess the methodological quality of the included trials. However, in Chapter 8 of the latest edition of the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011), it is suggested that scales that yield a summary score should be avoided. In accordance with this suggestion, we no longer used the PEDro Scale to assess the methodological quality of the included trials. Instead, we used the Cochrane 'Risk of bias' tool to analyse trial methodology as suggested by the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011).

In the protocol, it was planned to test the homogeneity between trial results using the Chi^2 test and, if there was statistically significant heterogeneity ($P < 0.10$), to calculate the overall effects using a random-effects model and perform a series of sensitivity analyses to investigate. In this update, we estimated all effects using a random-effects model, regardless of the level of heterogeneity.

In the protocol, it was planned to calculate relative risks and 95% confidence intervals for dichotomous variables. In this update, we used risk differences for dichotomous variables because many studies reported no events and it was therefore not possible to calculate relative risks.

In the protocol, it was planned to include participant quality of life, ability to perform activities of daily living, and the combined outcomes of 'death or dependency' and 'death or institutional care'. However, we did not find enough studies to perform such analyses.

INDEX TERMS

Medical Subject Headings (MeSH)

*Walking Speed; Body Weight; Exercise Therapy [instrumentation] [*methods]; Orthotic Devices; Patient Dropouts [statistics & numerical data]; Randomized Controlled Trials as Topic; Stroke Rehabilitation [*methods]; Walking; Weight-Bearing

MeSH check words

Humans; Middle Aged