Table SI. Search strategy for MEDLINE

#	**Query**
1	exp Cerebral infarction/
2	exp Cerebral ischemia/
3	exp Cerebrovascular disorders/
4	exp stroke/
5	1 or 2 or 3 or 4
6	stoke.mp. [mp=abstract, heading words, title]
7	5 or 6
8	exp Self efficacy/
9	"fear$ + fall$".mp. [mp=abstract, heading words, title]
10	"balance + confidence".mp. [mp=abstract, heading words, title]
11	"self efficacy".mp. [mp=abstract, heading words, title]
12	8 or 9 or 10 or 11
13	7 and 12
14	limit 13 to english

Table SII. Scottish Intercollegiate Guidelines Network (SIGN) methodology checklists for cohort studies

1.1	The study addresses an appropriate and clearly focused question.	Yes □ No □ Can't say □
1.2	The two groups being studied are selected from source populations that are comparable in all respects other than the factor under investigation.	Yes □ No □ Can't say □ Does not apply □
1.3	The study indicates how many of the people asked to take part did so, in each of the groups being studied.	Yes □ No □ Does not apply □
1.4	The likelihood that some eligible subjects might have the outcome at the time of enrolment is assessed and taken into account in the analysis.	Yes □ No □ Can't say □ Does not apply □
1.5#	What percentage of individuals or clusters recruited into each arm of the study dropped out before the study was completed.	Yes if loss to follow-up ≤ 20% No if loss to follow up >20%
1.6	Comparison is made between full participants and those lost to follow up, by exposure status.	Yes □ No □ Can't say □ Does not apply □
1.7	The outcomes are clearly defined.	Yes □ No □ Can't say □
1.8	The assessment of outcome is made blind to exposure status. If the study is retrospective this may not be applicable.	Yes □ No □ Can't say □
1.9	Where blinding was not possible, there is some recognition that knowledge of exposure status could have influenced the assessment of outcome.	Yes □ No □ Can't say □
1.10	The method of assessment of exposure is reliable.	Yes □ No □

		Can't say □
1.11	Evidence from other sources is used to demonstrate that the method of outcome assessment is valid and reliable.	Yes □ No □ Can't say □ Does not apply □
1.12	Exposure level or prognostic factor is assessed more than once.	Yes □ No □ Can't say □ Does not apply □
1.13	The main potential confounders are identified and taken into account in the design and analysis.	Yes □ No □ Can't say □
1.14	Have confidence intervals been provided?	Yes □ No □
2.1^	How well was the study done to minimise the risk of bias or confounding?	High quality (++) □ Acceptable (+) □ Unacceptable – reject 0

criterion set by the authors of the present review

^ criterion set by the authors of the present review- studies yielded <7 positive answers to the 14 questions would have 'unacceptable' study quality, ≥7 to 10 as 'acceptable' quality and ≥10 as 'high' quality.

Table SIII. Criteria used to downgrade ratings in the Grades of Recommendation, Assessment, Development and Evaluation (GRADE) system

Risk of bias [25]

- If meta-analysis of an outcome was allowed, <50% of included studies with an acceptable SIGN grade
- If meta-analysis of an outcome not allowed, <50% of the included studies with a high SIGN grade

Inconsistency [26]

- If I^2 > 50% in the primary meta-analysis of an outcome, i.e. indicating a clinical or methodological heteriogenity in the included studies
- Indirectness [27]
- If the study participants and outcome measures did not match between the included studies and the eligibility criteria of this review
- If studies used surrogate outcome measures

Imprecision [28]

- If total number of participants included in the primary meta-analysis less than the number of participants required for a single adequately powered trial using a conventional sample size calculation
- If the 95% CI spreading over zero for continuous variables or over one for OR and RR

Publication bias [29]

- If studies were industry sponsored
- If the authors indicated conflict of interest
- A funnel plot would be conducted if ≥ 10 studies in the meta-analyses [21]

Table SIV. Sensitivity analyses of outcomes

	Random effect model		Fixed model effects		Removal of studies	Comments
1-question survey	RR (95%CI)	I^2 / Z	RR (95%CI)	I^2 (*p*)/ Z (*p*)		
Falls risk at ***all stages*** (7 studies)	1.31 (1.14, 1.51)	$Tau^2 = 0.01$; $Chi^2 = 9.19$ ($p = 0.16$); $I^2 = 35\%$ Test for overall effect: Z = 3.77 ($p = 0.0002$)	1.37 (1.22, 1.54)	$Chi^2 = 9.19$ ($p = 0.16$); $I^2 = 35\%$ Test for overall effect: Z = 5.40 ($p < 0.00001$)	-	No significant difference using either random or fixed effect model
Falls risk ***at all stages*** (6 studies)	1.32 (1.12, 1.57)	$Tau^2 = 0.02$; $Chi^2 = 8.21$ ($p = 0.14$); $I^2 = 39\%$ Test for overall effect: Z = 3.24 ($p = 0.001$)	1.39 (1.22, 1.57)	$Chi^2 = 8.21$ ($p = 0.14$); $I^2 = 39\%$ Test for overall effect: Z = 5.16 ($p < 0.00001$)	Bugdayci et al 2011 [36]	No signficant difference by removing the only study of unacceptable quality
Falls risk at ***acute stage*** (3 studies)	1.44 (1.22, 1.70)	$Tau^2 = 0.00$; $Chi^2 = 0.54$ ($p = 0.76$); $I^2 = 0\%$	1.42 (1.19, 1.69)	$Chi^2 = 0.54$ ($p = 0.76$); $I^2 = 0\%$ Test for overall effect: Z = 3.90 ($p < 0.0001$)	-	No significant difference using either random or fixed effect model

		Test for overall effect: Z = 4.23 (p < 0.0001)				
Falls risk at ***acute stage*** (2 studies)	1.48 (1.21, 1.79)	Tau^2 = 0.00; Chi^2 = 0.24 (p = 0.62); I^2 = 0% Test for overall effect: Z = 3.91 (p < 0.0001)	1.47 (1.21, 1.79)	Chi^2 = 0.24 (p = 0.62); I^2 = 0% Test for overall effect: Z = 3.88 (p = 0.0001)	Schinkel-Ivy et al 2016 [50]	No signficant difference by removing the only retrospective study
Falls risk at ***chronic stage*** (4 studies)	1.21 (0.96, 1.54)	Tau^2 = 0.03; Chi^2 = 7.77 (p = 0.05); I^2 = 61% Test for overall effect: Z = 1.61 (p = 0.11)	1.33 (1.15, 1.55)	Chi^2 = 7.77 (p = 0.05); I^2 = 61% Test for overall effect: Z = 3.75 (p = 0.0002)	-	Significant difference indicating that the MA favours studies with smaller sample size [21]
Falls risk at ***chronic stage*** (3 studies)	1.18 (0.81, 1.71)	Tau^2 = 0.08; Chi^2 = 7.30 (p = 0.03); I^2 = 73% Test for overall effect: Z = 0.86 (p = 0.39)	1.36 (1.14, 1.62)	Chi^2 = 7.30 (p = 0.03); I^2 = 73% Test for overall effect: Z = 3.41 (p = 0.0007)	Bugdayci et al 2011 [36]	No signficant difference by removing the only study of unacceptable quality

FES	MD (95%CI)	I^2 / Z	MD (95%CI)	I^2 (*p*)/ Z (*p*)		
Chronic stage (4 studies)	12.80 (1.81, 23.78)	Tau^2 = 95.93; Chi^2 = 14.11 (*p* = 0.003); I^2 = 79% Test for overall effect: Z = 2.28 (*p* = 0.02)	9.70 (4.94, 14.46)	Chi^2 = 14.11 (*p* = 0.003); I^2 = 79% Test for overall effect: Z = 3.99 (*p* < 0.0001)	-	No significant difference using either random or fixed effect model
Chronic stage (3 studies)	6.71 (0.41, 13.01)	Tau^2 = 8.93; Chi^2 = 2.78 (*p* = 0.25); I^2 = 28% Test for overall effect: Z = 2.09 (*p* = 0.04)	6.41 (1.28, 11.54)	Chi^2 = 2.78 (*p* = 0.25); I^2 = 28% Test for overall effect: Z = 2.45 (*p* = 0.01)	Kongwattanakul et al 2020 [41]	No signficant difference in MD by removing the only study with participants with explicitly more severe spasticity but significantly reduced I^2
ABC	MD (95%CI)	I^2 / Z	MD (95%CI)	I^2 (*p*)/ Z (*p*)		
Chronic stage (7 studies)	-12.65 (-20.75, -4.55)	Tau^2 = 97.79; Chi^2 = 47.35 (*p* < 0.00001); I^2 = 87%	-15.51 (-18.17, -12.85)	Chi^2 = 47.35 (*p* < 0.00001); I^2 = 87%	-	No significant difference using either random or fixed effect model

		Test for overall effect: Z = 3.05 (*p* = 0.002)		Test for overall effect: Z = 11.43 (*p* < 0.00001)		
Chronic stage (6 studies)	-9.99 (-15.36, -4.62)	Tau^2 = 23.56; Chi^2 = 11.57 (*p* = 0.04); I^2 = 57% Test for overall effect: Z = 3.64 (*p* = 0.0003)	-10.24 (-13.41, -7.07)	Chi^2 = 11.57 (*p* = 0.04); I^2 = 57% Test for overall effect: Z = 6.33 (*p* < 0.00001)	Sahin et al 2019 [49]	No signficant difference in MD by removing the study with participants able to stand independently for 2 minutes but reduced I^2 shown

ABC- Activities-specific Balance Confidence Scale; CI- conference interval; FES- Falls Efficacy Scale; MD- mean differences; RR- relative risk ratio